

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07171

Dr. Ellis

7168

CERTIFICATE OF DEATH

(Husband ~~EX~~ Mr. Arthur S. Ahrens)

Reg. Dist. No. 232

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
12 Salisbury				12 Salisbury		1	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 Pen. Gen. Hospital				309 New York Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. AGE last birthday	
(First) GRACE (Middle) LORENE (Last) AHRENS				Month July Day 9 Year th 19 55		IF UNDER 1 YEAR IF UNDER 24 HRS.	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	Months	Days	Hours
Female	White	Widowed	Sept. 12, 1900	54 yrs.	9	27	15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House Work		at own home		Uhrichsville Ohio		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Peter Albert Schupp				Elizabeth Stokes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No (If Yes, give war or dates of service)				Mrs. Estelle Joy (Sister) 431 Oakdale Ave. Chicago, Ill.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260X IMMEDIATE CAUSE (A) General Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 3 days			
ANTECEDENT CAUSE(S) DUE TO (B) Arterio-sclerotic Heart Disease				concurrent			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Diabetes mellitus				15			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.							
SIGNATURE Dr. Ellis				DATE SIGNED Camden Ave. Salisbury, Maryland July 1955			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 13, 1955		Union Cemetery		Uhrichsville, Ohio	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE July 13, 1955		B. J. Wayte		HOLLOWAY & COMPANY		SALISBURY MARYLAND	

(Continued on next page)

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6. 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681,

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7169

07172

CERTIFICATE OF DEATH

Dr. Burton

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY Wicomico MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wicomico CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury STREET ADDRESS (If rural give location) John B. Parsons Home for the Age			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) ROSA ALEXANDER				DATE OF DEATH (Month) (Day) (Year) July 11 th 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Nov. 10, 1869	9. AGE last birthday 85 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sampson Downing				14. MOTHER'S MAIDEN NAME Marianna Tilghman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Records-John B. Parsons Home for the Age Salisbury, Maryland			
18. MEDICAL CERTIFICATION 1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) Barbed Thoracic ANTECEDENT CAUSE(S) DUE TO (B) Generalized arterio sclerosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Hypertensive arterio sclerosis cardio vascular changes				INTERVAL BETWEEN ONSET AND DEATH 2 wks. Year Year			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/13/55 to 7/11/55 , that I last saw the deceased alive on 7/11/55 , and that death occurred at 8:00A. M., from the causes and on the date stated above.							
SIGNATURE Andrew C. Mitchell M.D.				ADDRESS (Street, city, town, state) Maryland Ave. Salisbury, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 13, 1955		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR DATE July 14, 1955		REGISTRAR'S SIGNATURE Mary Holloway &		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

IV. AUTHOR

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. PLACE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. DATE OF REGISTRATION

14. PLACE OF REGISTRATION

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF DECEASED

17. SIGNATURE OF PHYSICIAN

18. SIGNATURE OF REGISTRAR

19. SIGNATURE OF WITNESSES

20. SIGNATURE OF DECEASED

BUREAU V. 3

JUL 14 1955

RECEIVED

8:00A

MARYLAND STATE DEPARTMENT OF HEALTH

BALTIMORE, MARYLAND

REGISTRAR

JUL 13, 1955

SERIAL

HOLWAY & COMPANY BALTIMORE MARYLAND

REPRODUCTION

This is a reproduction of the original certificate of death, which is the legal document for the purpose of recording the death of a person. It is not to be used for any other purpose. The original certificate of death is the only legal document for the purpose of recording the death of a person. It is not to be used for any other purpose. The original certificate of death is the only legal document for the purpose of recording the death of a person. It is not to be used for any other purpose.

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07173

7170

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
12 TOWN <u>Salisbury</u>		4 years		TOWN <u>Westminster</u>		06-27-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Ellis</u>		(Middle) <u>Monroe</u>		(Last) <u>Arnold</u>		July 28 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Widowed	August 29, 1871	83 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Basil Arnold				Sallie Knight			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.				Hospital records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, generalized</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerotic cardiovascular disease</u>						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 17, 1951</u> , to <u>July 28, 1955</u> , that I last saw the deceased alive on <u>July 28, 1955</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>		ADDRESS (Street, city, town, state) <u>Deer's Head Hospital, Salisbury, Maryland</u>		DATE SIGNED <u>7/29/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>Aug 1/55</u>		<u>Harfieldburg Cem.</u>		<u>Carroll Co</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Aug. 2, 1955</u>		<u>Mary H. Holloway</u>		<u>H. Bankhead Son Westminster Md</u>			

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Duration of illness

10. Signature of physician

11. Signature of registrar

12. Signature of medical examiner

13. Signature of coroner

14. Signature of funeral director

15. Signature of undertaker

16. Signature of cemetery

17. Signature of burial place

18. Signature of interment

19. Signature of record

20. Signature of office

BUREAU V. 1

AUG 2 1955

RECEIVED

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1515 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07174

Dr. Sohler

CERTIFICATE OF DEATH

Reg. Dist. No. 832

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL end give nearest town) Parsonsburg		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town) Parsonsburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 2				STREET ADDRESS (If rural give location) R.D. # 2			
3. NAME OF DECEASED (Type or Print) MARY (First) IRCHIE (Middle) ARVEY (Last)				4. DATE OF DEATH (Month) July (Day) 9 (Year) th 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH March 28, 1880	9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months 4 Days 11	IF UNDER 24 HRS. Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At own home		11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Mitchell				14. MOTHER'S MAIDEN NAME Laura McDowell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Bulah Tyer (Grand Daughter) R.D. # 2 Parsonsburg, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) arteriosclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH 4 years			
ANTECEDENT CAUSE(S) DUE TO (B) coronary arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) arteriosclerosis generalized.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 5, 1955 , to July 9, 1955 , that I last saw the deceased alive on July 5, 1955 , and that death occurred at 7:35P.M. , from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city, town, state) Delmar, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF July 12, 1955		NAME OF CEMETERY OR CREMATORY Bethel Cemetery - Walston - R.D. # 2 Parsonsburg, Md.	
24. REC'D BY REGISTRAR DATE July 13, 1955		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND			

CERTIFICATE OF DEATH

Dr. Goffner

Age 45

Male

White

Married

Married

Residence

Residence

1955

July

13

1955

1955

11

11

1955

1955

White

House Work

At own home

At own home

John Mitchell

John Mitchell

Mrs. John Mitchell (Granddaughter), R.D. 1, Baltimore, Maryland

BUREAU V. 2

JUL 13 1955

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July 13, 1955 - Baltimore - Maryland - R.D. 1, Baltimore, Md.

FOOTWAY & COMPANY, BALTIMORE, MARYLAND

7223

07175

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>WICOMICO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>WICOMICO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>MARDELA SPRINGS</u>			
X TOWN <u>MARDELA SPRINGS</u>		<u>26 YRS</u>		STREET ADDRESS (If rural, give location) <u>NEAR MARDELA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>NEAR MARDELA</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Edgar Clifton Bacon Jr.</u>				<u>7 16 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>AUG 24 1899</u>	9. AGE last birthday: <u>56</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>HOME</u>		11. BIRTHPLACE (State or foreign country): <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>CHARLES W. BACON</u>				14. MOTHER'S MAIDEN NAME: <u>FLORANCE SHOCKLEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY No.: <u>017-047-6997</u>		17. INFORMANT & ADDRESS: <u>MRS EDGAR BACON</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET OF DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) DUE TO <u>CORONARY OCCLUSION</u>							
Antecedent cause(s) (b) DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Earl L. Kruger</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>7-18-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>7-19-55</u>		NAME OF CEMETERY OR CREMATORY: <u>MARDELA</u>		LOCATION (City, town, or county) (State): <u>MARDELA SPRINGS MD</u>	
DATE REC'D BY LOCAL REG: <u>7-20-55</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR: <u>Thelma Smith, Shoptown, Md</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 28 1955

RECEIVED

7171

CERTIFICATE OF DEATH

Reg. Dist. No. 33

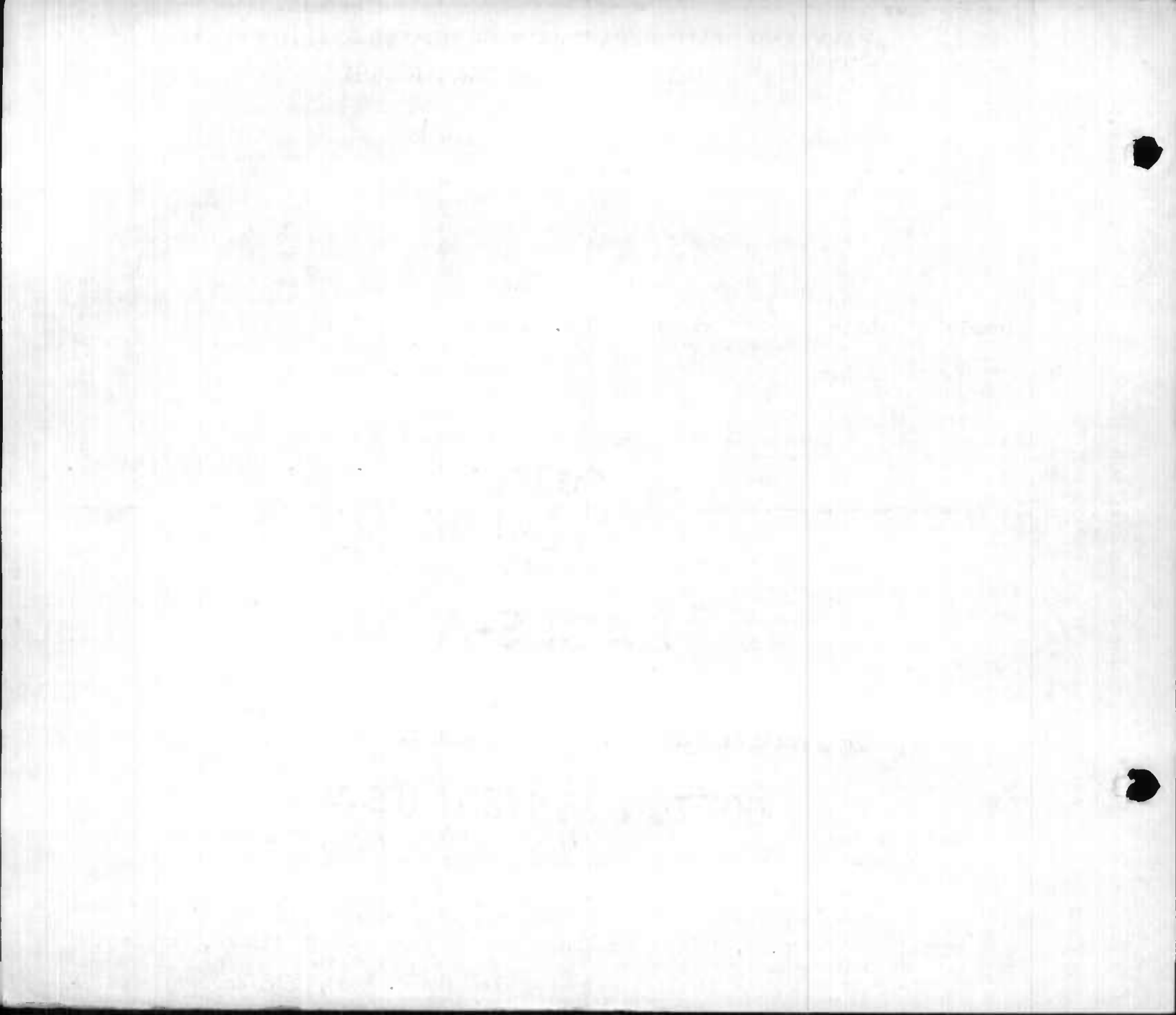
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Balto.</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>			
12. TOWN <i>Salisbury</i>				03X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>				STREET ADDRESS (If rural give location) <i>3127 Astor Road - Rockville</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) <i>Mary</i>		(Middle) <i>Ellen</i>		(Last) <i>Bond</i>			
5. SEX: <i>female</i>		6. COLOR OR RACE: <i>white</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>		8. DATE OF BIRTH: <i>Nov. 6, 1886</i>	
				9. AGE last birthday <i>68</i> yrs.		10. DATE OF DEATH: <i>July 27, 1955</i>	
						11. BIRTHPLACE (State or foreign country): <i>Baltimore, Maryland</i>	
						12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>George Wilmer</i>				14. MOTHER'S MAIDEN NAME: <i>Louise</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS: <i>Mr. Albert W. Bond, 3105 Moreland Ave.</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Cerebro - Vascular Accident</i>			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7/20, 1955</i> , to <i>7/27, 1955</i> that I last saw the deceased alive on <i>7/26, 1955</i> , and that death occurred at <i>6:28 PM</i> , from the causes and on the date stated above.					
SIGNATURE <i>G. C. Mitchell</i>		ADDRESS <i>M. D. Salisbury, Ind</i>		DATE SIGNED <i>7/27/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Aug. 1, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial Park</i>	
				LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>7-27-55</i>		REGISTRAR'S SIGNATURE <i>Leonard J. Ruck</i>		24. FUNERAL DIRECTOR ADDRESS <i>5305 Harford Road #14</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07178

7172

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>10 months</u>		TOWN <u>Claiborne</u>		<u>20X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Corneilous Brooks</u>				<u>July 29 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Colored</u>	<u>Widowed</u>	<u>Dec. 1876</u>	<u>78</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unknown</u>		<u>Unknown</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joseph Brooks</u>				<u>Sally Causey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>				<u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>332X</u> IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>02687</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>?</u>	
<u>CNS syphilis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that attended the deceased from <u>Oct. 7</u> , 19 <u>54</u> , to <u>July 29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 29</u> , 19 <u>55</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		DATE		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>L.V. Maldve</u>		<u>8/1/55</u>		<u>Deer's Head State Hospital</u>		<u>7/29/55</u>	
				<u>Salisbury, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8/1/55</u>		<u>Claiborne Cemetery</u>		<u>Claiborne, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Aug. 3, 1955</u>		<u>Mary W. Holloway</u>		<u>Norman D. Marshall</u>			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07179

7173

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		3 yrs.		OR TOWN <u>Pikesville</u>		03X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Edith Parrish Bullock</u>				<u>July 18 19 55</u>			
5. SEX	6. RACE OR COLOR	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Dec. 14, 1878</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unk.</u>		<u>Unk.</u>		<u>Baltimore, Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James H. Parrish</u>				<u>Emily M. Sanderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>36 hrs</u>	
443X IMMEDIATE CAUSE (A) <u>Myocardial insufficiency</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive arteriosclerotic cardiovascular disease</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 5</u> , 19 <u>52</u> , to <u>July 18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 18</u> , 19 <u>55</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>		L.V. Maldve, M.D.		ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital Salisbury, Maryland</u>		DATE SIGNED <u>7/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>July-21-1955</u>		NAME OF CEMETERY OR CREMATORY <u>GreenMount</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>7-19-55</u>		REGISTRAR'S SIGNATURE <u>?</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart & Mowen Co. Balto., Md.</u>		ADDRESS	

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

071810VC

7174

CERTIFICATE OF DEATH

Reg. Dist. No. 932

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN Salisbury		3 1/2 years		TOWN Linthicum		02X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital				STREET ADDRESS 608 Broadview Blvd. (If rural, give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
Sarah		Burke		July 21		19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
Female	White	Single	Aug. 10, 1865	89			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown		Providence, R. I.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Burke				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.		Unk.		Hospital records			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
491X IMMEDIATE CAUSE (A) Bronchopneumonia						INTERVAL BETWEEN ONSET AND DEATH 1 week	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
-- --		-- --					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 8, 1951 , to July 21, 1955 , that I last saw the deceased alive on July 21, 1955 , and that death occurred at 8:40 P.M. from the causes and on the date stated above.							
SIGNATURE <i>R. J. Lore</i>				DATE SIGNED 7/22/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial				Speddens-Sewards Cemetery		James, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 7-25-55		<i>Mary W. Holloway</i>		<i>LeCompte Funeral Service</i>		Cambridge, Maryland	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES HENRY HARRIS JR.		2. SEX Male		3. AGE 35 years		4. PLACE OF BIRTH Boston, Mass.	
5. OCCUPATION Salesman		6. MARITAL STATUS Married		7. DATE OF DEATH July 26, 1955		8. PLACE OF DEATH Home	
9. CAUSE OF DEATH Myocardial Infarction		10. MANNER OF DEATH Natural		11. SIGNATURE OF PHYSICIAN [Signature]		12. SIGNATURE OF REGISTRAR [Signature]	
13. MEDICAL HISTORY [Blank]		14. SOCIAL HISTORY [Blank]		15. PATHOLOGICAL FINDINGS [Blank]		16. OTHER FINDINGS [Blank]	

THIS CERTIFICATE OF DEATH IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BOSTON, MASSACHUSETTS, AND IS TO BE MADE AVAILABLE TO THE PUBLIC UPON REQUEST.

BUREAU V. 2

JUL 26 1955

RECEIVED

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

RECEIVED

JUL 11 1955

BUREAU V. S.

1. NAME OF DECEASED JAMES J. JONES		2. SEX M		3. AGE 45	
4. PLACE OF BIRTH BOSTON, MASS.		5. DATE OF BIRTH JUL 15, 1910		6. PLACE OF DEATH BOSTON, MASS.	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. SIGNATURE OF PHYSICIAN J. J. JONES	
10. SIGNATURE OF REGISTRAR J. J. JONES		11. SIGNATURE OF CLERK J. J. JONES		12. SIGNATURE OF DECEASED J. J. JONES	
13. SIGNATURE OF WITNESS J. J. JONES		14. SIGNATURE OF DECEASED J. J. JONES		15. SIGNATURE OF DECEASED J. J. JONES	
16. SIGNATURE OF DECEASED J. J. JONES		17. SIGNATURE OF DECEASED J. J. JONES		18. SIGNATURE OF DECEASED J. J. JONES	
19. SIGNATURE OF DECEASED J. J. JONES		20. SIGNATURE OF DECEASED J. J. JONES		21. SIGNATURE OF DECEASED J. J. JONES	
22. SIGNATURE OF DECEASED J. J. JONES		23. SIGNATURE OF DECEASED J. J. JONES		24. SIGNATURE OF DECEASED J. J. JONES	
25. SIGNATURE OF DECEASED J. J. JONES		26. SIGNATURE OF DECEASED J. J. JONES		27. SIGNATURE OF DECEASED J. J. JONES	
28. SIGNATURE OF DECEASED J. J. JONES		29. SIGNATURE OF DECEASED J. J. JONES		30. SIGNATURE OF DECEASED J. J. JONES	
31. SIGNATURE OF DECEASED J. J. JONES		32. SIGNATURE OF DECEASED J. J. JONES		33. SIGNATURE OF DECEASED J. J. JONES	
34. SIGNATURE OF DECEASED J. J. JONES		35. SIGNATURE OF DECEASED J. J. JONES		36. SIGNATURE OF DECEASED J. J. JONES	
37. SIGNATURE OF DECEASED J. J. JONES		38. SIGNATURE OF DECEASED J. J. JONES		39. SIGNATURE OF DECEASED J. J. JONES	
40. SIGNATURE OF DECEASED J. J. JONES		41. SIGNATURE OF DECEASED J. J. JONES		42. SIGNATURE OF DECEASED J. J. JONES	
43. SIGNATURE OF DECEASED J. J. JONES		44. SIGNATURE OF DECEASED J. J. JONES		45. SIGNATURE OF DECEASED J. J. JONES	
46. SIGNATURE OF DECEASED J. J. JONES		47. SIGNATURE OF DECEASED J. J. JONES		48. SIGNATURE OF DECEASED J. J. JONES	
49. SIGNATURE OF DECEASED J. J. JONES		50. SIGNATURE OF DECEASED J. J. JONES		51. SIGNATURE OF DECEASED J. J. JONES	
52. SIGNATURE OF DECEASED J. J. JONES		53. SIGNATURE OF DECEASED J. J. JONES		54. SIGNATURE OF DECEASED J. J. JONES	
55. SIGNATURE OF DECEASED J. J. JONES		56. SIGNATURE OF DECEASED J. J. JONES		57. SIGNATURE OF DECEASED J. J. JONES	
58. SIGNATURE OF DECEASED J. J. JONES		59. SIGNATURE OF DECEASED J. J. JONES		60. SIGNATURE OF DECEASED J. J. JONES	
61. SIGNATURE OF DECEASED J. J. JONES		62. SIGNATURE OF DECEASED J. J. JONES		63. SIGNATURE OF DECEASED J. J. JONES	
64. SIGNATURE OF DECEASED J. J. JONES		65. SIGNATURE OF DECEASED J. J. JONES		66. SIGNATURE OF DECEASED J. J. JONES	
67. SIGNATURE OF DECEASED J. J. JONES		68. SIGNATURE OF DECEASED J. J. JONES		69. SIGNATURE OF DECEASED J. J. JONES	
70. SIGNATURE OF DECEASED J. J. JONES		71. SIGNATURE OF DECEASED J. J. JONES		72. SIGNATURE OF DECEASED J. J. JONES	
73. SIGNATURE OF DECEASED J. J. JONES		74. SIGNATURE OF DECEASED J. J. JONES		75. SIGNATURE OF DECEASED J. J. JONES	
76. SIGNATURE OF DECEASED J. J. JONES		77. SIGNATURE OF DECEASED J. J. JONES		78. SIGNATURE OF DECEASED J. J. JONES	
79. SIGNATURE OF DECEASED J. J. JONES		80. SIGNATURE OF DECEASED J. J. JONES		81. SIGNATURE OF DECEASED J. J. JONES	
82. SIGNATURE OF DECEASED J. J. JONES		83. SIGNATURE OF DECEASED J. J. JONES		84. SIGNATURE OF DECEASED J. J. JONES	
85. SIGNATURE OF DECEASED J. J. JONES		86. SIGNATURE OF DECEASED J. J. JONES		87. SIGNATURE OF DECEASED J. J. JONES	
88. SIGNATURE OF DECEASED J. J. JONES		89. SIGNATURE OF DECEASED J. J. JONES		90. SIGNATURE OF DECEASED J. J. JONES	
91. SIGNATURE OF DECEASED J. J. JONES		92. SIGNATURE OF DECEASED J. J. JONES		93. SIGNATURE OF DECEASED J. J. JONES	
94. SIGNATURE OF DECEASED J. J. JONES		95. SIGNATURE OF DECEASED J. J. JONES		96. SIGNATURE OF DECEASED J. J. JONES	
97. SIGNATURE OF DECEASED J. J. JONES		98. SIGNATURE OF DECEASED J. J. JONES		99. SIGNATURE OF DECEASED J. J. JONES	
100. SIGNATURE OF DECEASED J. J. JONES		101. SIGNATURE OF DECEASED J. J. JONES		102. SIGNATURE OF DECEASED J. J. JONES	

ENCLOSURE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

7224

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07182

CERTIFICATE OF DEATH

Item 5, FilmG184 8-4-55 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Fruitland		LENGTH OF STAY (in this place) Most of life		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fruitland		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - Fruitland				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED (First) (Middle) (Last) Harvey Benjamin Christopher				4. DATE OF DEATH (Month) (Day) (Year) 7 - 25 - 19 55			
5. SEX Male		6. COLOR OR RACE A.A.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 1883	
9. AGE last birthday 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Delany's Factory		11. BIRTHPLACE (State or foreign country) Fruitland, Wicomico Co.Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Christopher				14. MOTHER'S MAIDEN NAME Sarah Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 213-18-5374		17. INFORMANT & ADDRESS Mrs. Elizabeth Christopher, Fruitland, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 420.1				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				Coronary Artery Disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				Hypertension Heart Disease			
STATING UNDERLYING CAUSE LAST. DUE TO				Dilatation - Hypertension			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Nephritis			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 28, 1955</u> to <u>July 24, 1955</u>, that I last saw the deceased alive on <u>June 28, 1955</u>, and that death occurred at <u>11:30</u> M. from the causes and on the date stated above.							
SIGNATURE G. Herbert Sewley M.D.				DATE SIGNED 7/26/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-28-55		NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		LOCATION (City, town, or county) Fruitland, Wicomico Co., Md.	
24. REC'D BY REGISTRAR Mary H. Holloway		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart			
DATE July 21, 1955				ADDRESS 324 E. Church St. Salisbury, Md.			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

REG. NO. 100

A. NAME AND ADDRESS OF DECEASED

John Maryland, County Wisconsin

Trinidad

Place of Birth

Trinidad

At home - Ford Lane

And together

Benjamin

Harvey

75

1881

Married

Female

Female

Trinidad, Wisconsin Co., Wis.

Trinidad, Wisconsin Co., Wis.

Trinidad

Edward Christopher

Edward Christopher

Trinidad, Wisconsin Co., Wis.

Trinidad, Wisconsin Co., Wis.

Trinidad

Trinidad

BUREAU V. S.

JUL 28 1955

RECEIVED

Trinidad, Wisconsin Co., Wis.

Trinidad, Wisconsin Co., Wis.

Trinidad

Trinidad

SMOOTHJURIN

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the funeral director, the third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07183

7176

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 8, Film 84 7-28-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Baltimore City			
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place) 1 Day		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore		TOWN 3 Vo 1-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital		STREET ADDRESS (If rural give location) 906 Dartmouth Rd.,					
3. NAME OF DECEASED (Type or Print) HERMAN WESTLER COOPER				4. DATE OF DEATH (Month) (Day) (Year) 7 22 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 15, 1955 1895	9. AGE last birthday 60 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Distributor		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mrs Madge Elise Cooper, Same			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Coronary Artery Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 3 days			
ANTECEDENT CAUSE(S) DUE TO (B) Coronary Atherosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 20, 1955 to July 22, 1955 , that I last saw the deceased alive on July 22, 1955 , and that death occurred at 1:45 PM , from the causes and on the date stated above.							
SIGNATURE David J. Salmore		M.D.		ADDRESS (Street, city, town, state) Salisbury, Md.		DATE SIGNED July 23, 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/25/55		NAME OF CEMETERY OR CREMATORY Elmwood Ave. Cemetery		LOCATION (City, town, or county) (State) Columbia, S.C.	
24. REC'D BY REGISTRAR 7-25-55		REGISTRAR'S SIGNATURE Mary H. Hallaway		25. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co.		ADDRESS Salisbury, Maryland	

Norman T. Baker

CERTIFICATE OF DEATH

Reg. Form No. 1

1. Name of deceased: **John Henry Jones**

2. Date of death: **July 15, 1955**

3. Place of death: **Home**

4. Cause of death: **Heart Disease**

5. Place of birth: **Baltimore, Md.**

6. Age at death: **65**

7. Sex: **Male**

8. Race: **White**

9. Date of birth: **July 15, 1955**

10. Occupation: **Editor**

11. Name of physician: **Dr. J. H. Jones**

12. Name of funeral home: **Union**

13. Name of undertaker: **Union**

14. Name of informant: **John Henry Jones**

15. Name of informant: **John Henry Jones**

16. Name of informant: **John Henry Jones**

BUREAU V. S.

JUL 25 1955

RECEIVED

Columbia, S.C.

Elwood Ave. Cemetery

7-25-55

Bureau

The Hall & Johnson Co., Baltimore, Maryland

EXHIBITION

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07184

7225

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Fruitland		LENGTH OF STAY (in this place) Most of life		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Fruitland X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - Fruitland				STREET ADDRESS (If rural give location) /			
3. NAME OF DECEASED (Type or Print) Allene Virginia Dennis				4. DATE OF DEATH (Month) (Day) (Year) 7 - 29 - 19 55			
5. SEX Female	6. COLOR OR RACE A.A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 4-12-1901		9. AGE last birthday 54 yrs.		IF UNDER 1 YEAR Months 3 Days 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Fruitland, Wicomico Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Mary Shockley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS George Dennis, Fruitland, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260X IMMEDIATE CAUSE (A) Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 weeks			
ANTECEDENT CAUSE(S) DUE TO (B) Nephritis & Edema							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) late-calcifying Glomerulonephritis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertension; atherosclerosis				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 15, 1955 , to July 29, 1955 , that I last saw the deceased alive on July 29, 1955 , and that death occurred at 4:40 M. from the causes and on the date stated above.							
SIGNATURE Mary H. Holloway				ADDRESS (Street, city, town, state) Salisbury, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8-3-55		NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery		LOCATION (City, town, or county) (State) Fruitland, Wicomico Co., Md.	
24. REC'D BY REGISTRAR Aug. 2, 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart			
				ADDRESS 324 E. Church St. Salisbury, Maryland.			

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE

1. NAME OF DECEASED	2. SEX	3. AGE	4. DATE OF BIRTH	5. PLACE OF BIRTH	6. PLACE OF DEATH	7. CAUSE OF DEATH	8. MANNER OF DEATH	9. SIGNATURE OF REGISTRAR
WILLIAM	Male	45	1910-10-10	Frederick, Maryland	Frederick, Maryland	Heart Disease	At home	
WILLIAM	Male	45	1910-10-10	Frederick, Maryland	Frederick, Maryland	Heart Disease	At home	
WILLIAM	Male	45	1910-10-10	Frederick, Maryland	Frederick, Maryland	Heart Disease	At home	
WILLIAM	Male	45	1910-10-10	Frederick, Maryland	Frederick, Maryland	Heart Disease	At home	
WILLIAM	Male	45	1910-10-10	Frederick, Maryland	Frederick, Maryland	Heart Disease	At home	
WILLIAM	Male	45	1910-10-10	Frederick, Maryland	Frederick, Maryland	Heart Disease	At home	
WILLIAM	Male	45	1910-10-10	Frederick, Maryland	Frederick, Maryland	Heart Disease	At home	
WILLIAM	Male	45	1910-10-10	Frederick, Maryland	Frederick, Maryland	Heart Disease	At home	
WILLIAM	Male	45	1910-10-10	Frederick, Maryland	Frederick, Maryland	Heart Disease	At home	
WILLIAM	Male	45	1910-10-10	Frederick, Maryland	Frederick, Maryland	Heart Disease	At home	

BUREAU V. E.

AUG 2 1955

RECEIVED

PHOTOGRAPH

THE STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE
 This is to certify that the foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears in the records of the Department of Health, Baltimore, Maryland.
 WITNESSED my hand and the seal of the Department of Health, Baltimore, Maryland, this 2nd day of August, 1955.
 REGISTRAR

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7177

07185

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>6 Yrs.</u>		OR TOWN <u>Salisbury</u>		OR TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Hill Private Sanitarium</u>				STREET ADDRESS (If rural give location) <u>Maryland Ave.,</u>			
3. NAME OF DECEASED (Type or Print) <u>MARY GODFREY DICKERSON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7 20 19 55</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Jan. 28, 1863</u>	
9. AGE last birthday <u>92</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Robert F. Godfrey</u>			
14. MOTHER'S MAIDEN NAME <u>Mary F. Wimbrow</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS <u>Mrs Edith Dayton, 620 Light St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) <u>Cardiovascular renal disease</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) _____				_____			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____				_____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				_____			
19a. DATE OF OPERATION <u>7/22/55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		_____	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		_____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>7-20-55</u> to <u>July 20, 19 55</u> , that I last saw the deceased alive on <u>7-20-55</u> , 19 <u>55</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.				_____			
SIGNATURE <u>Theresa Lamb</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Maryland</u> DATE SIGNED <u>7-22-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>7-25-55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u> ADDRESS <u>The Hill & Johnson Co. Salisbury, Maryland</u>			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07186

7178

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>3 1/2 months</u>		TOWN <u>Salisbury</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>Route # 2</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Philip Grant Dickinson</u>				<u>July 20 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>11/5/1872</u>	<u>82</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Farming</u>		<u>Michigan</u>		<u>USA</u>	
13. FATHER'S NAME <u>Philip Reuben Dickinson</u>				14. MOTHER'S MAIDEN NAME <u>Sophronia Tibbets</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1991 IMMEDIATE CAUSE (A) <u>Generalized carcinomatosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Squamous cell carcinoma of left ear</u>						<u>2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Secondary anemia</u>						-	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTINUING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr. 4, 19 55</u> , to <u>July 20, 19 55</u> , that I last saw the deceased alive on <u>July 20, 19 55</u> , and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve, M.D.</u>		ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital Salisbury, Maryland</u>		DATE SIGNED <u>7/20/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 23, 1955</u>		<u>Wicomico Memorial Park</u>		<u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>7-25-55</u>		<u>Mary H. Holloway</u>		<u>HOLLOWAY & COMPANY</u>		<u>SALISBURY MARYLAND</u>	

CERTIFICATE OF DEATH

WARRANT STATE

WARRANT STATE OF ARIZONA

WARRANT STATE

WARRANT STATE

WARRANT STATE

WARRANT STATE

WARRANT STATE

WARRANT STATE

WARRANT STATE

WARRANT STATE

WARRANT STATE

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WARRANT STATE

WARRANT STATE

WARRANT STATE

BUREAU V. S.

JUL 25 1955

RECEIVED

WARRANT STATE

WARRANT STATE

7179

07187

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>md</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Salisbury</u>	<u>2 months</u>	TOWN <u>Baltimore</u>	<u>3v01-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head Hospital</u>		STREET ADDRESS (If rural, give location) <u>308 N. Pearl St.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>William</u>	(Middle) <u>Dockins</u>	(Month) <u>7</u>	(Day) <u>11</u>
(Type or Print)		(Year) <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>E</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>May 11, 1923</u>
		9. AGE last birthday: <u>32</u> yrs.	10. IF UNDER 1 YEAR: <u>IF UNDER 24 HRS.</u>
		Months <u>7</u> Days <u>11</u> Hours <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Unk.</u>	10b. KIND OF BUSINESS OR INDUSTRY: <u>Unk.</u>	11. BIRTHPLACE (State or foreign country): <u>Richmond, Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>William Dockins</u>		14. MOTHER'S MAIDEN NAME: <u>Clara Trice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service) <u>- -</u>		16. SOCIAL SECURITY No.: <u>Unk.</u>	
		17. INFORMANT & ADDRESS: <u>Hospital records</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>months</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<p>Immediate cause (a) <u>Pyelonephritis Bilateral</u></p> <p>Antecedent cause(s) (b) <u>600.0</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>DUE TO</u></p>		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumonia - Severe Thoracic Cord</u>		<u>1 yr.</u>
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19a. DATE OF OPERATION: <u>July 31 1954</u>	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
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21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (City or town) <u>Baltimore</u> (County) <u>md.</u> (State)
21d. TIME (Month) (Day) (Year) (Hour) <u>July 31 1954</u> <u>M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Shot by Edgan Harris after argument</u>

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

SIGNATURE Earl L. Boyer CHIEF MEDICAL EXAMINER ☒ DATE SIGNED 7-12-55

M. D. Francis A. Hendry DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): <u>7-16-55</u>	DATE THEREOF <u>7/18/55</u>	NAME OF CEMETERY OR CREMATORY <u>National Cemetery Baltimore md</u>	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <u>7-16-55</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>Mrs. Francis A. Hendry</u>	ADDRESS <u>1628 W. 19th St. Baltimore Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED

JUL 20 1955

BUREAU V. 2

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07188

7180

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		1 Wk		TOWN <u>Eden</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>82 Peninsula General Hospital</u>				<u>R7D#1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>James</u> (Middle) <u>Eberhart</u> (Last) <u>Eberhart</u>				(Month) <u>July</u> (Day) <u>28</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Aug. 28, 1910</u>	<u>44</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Trucking Contractor</u>		<u>Dump Trucks</u>		<u>Penna</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Benjamin Eberhardt</u>				<u>Jennie Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. D.J. Eberhardt, Same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
550.1 IMMEDIATE CAUSE (A)				<u>Peritonitis, Acute</u>		<u>9 days</u>	
ANTECEDENT CAUSE(S) DUE TO				<u>Ruptured appendix</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				<u>Ulcerative Colitis, Acute</u>			
(C)				<u>Multiple Sclerosis</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 22, 1955</u> , to <u>July 28, 1955</u> , that I last saw the deceased alive on <u>July 27, 1955</u> , and that death occurred at <u>10:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter D. Situm</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>July 28, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Nurial</u>		<u>8/1/55</u>		<u>Lewisburg Cemetery</u>		<u>Lewisburg, Penna.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Aug. 1, 1955</u>		<u>Mary H. Holloway</u>		<u>The Hill & Johnson Co. Salisbury, Md.</u>		<u>Norman T. Baker</u>	

CERTIFICATE OF DEATH

1. USUAL RESIDENCE (House or Apartment)

2. PLACE OF DEATH

3. DATE OF DEATH

4. SEX

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. MARITAL STATUS

8. OCCUPATION

9. NAME OF DECEASED

10. AGE

11. NAME OF PHYSICIAN

BUREAU V. S.

AUG 11 196

RECEIVED

The Hill & Johnson Co., Baltimore, Md.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07189

7181

CERTIFICATE OF DEATH

Reg. Dist. No. 322

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (If in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>4 years</u>		TOWN <u>Baltimore</u>		<u>3v01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>2516 N. Charles Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Frank</u> <u>Eisenhood</u>				<u>July 18</u> <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Dec. 5, 1876</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Unk.</u>		<u>Unk.</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Frederick Eisenhood</u>				14. MOTHER'S MAIDEN NAME <u>Mary Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, generalized</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic cardiovascular disease</u>						<u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 13, 1951</u> , to <u>July 18, 1955</u> , that I last saw the deceased alive on <u>July 18, 1955</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>		DATE THEREOF <u>7/20/55</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) <u>Salisbury, Md.</u>	
				M.D. <u>L.V. Maldve, M.D.</u>		DATE SIGNED <u>7/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Mary W. Holcomb</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Johnson</u>		ADDRESS <u>Salisbury, Md.</u>	
DATE <u>July 20, 1955</u>							

ADDRESS (Street, city, town, state)

DATE SIGNED

LOCATION (City, town, or county)

(State)

JUL 21 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7182
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>12 TOWN Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Berlin</u>		<u>23X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10</u>				STREET ADDRESS (If rural, give location) <u>N. Main St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Lillian Bertrude Fleming</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>7 8 1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Nov. 7, 1906</u>	9. AGE last birthday: <u>45</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY: <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John D. Wooten</u>				14. MOTHER'S MAIDEN NAME: <u>Ella Darby</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mr. Gilbert Fleming, Berlin, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>816X</u> Immediate cause (a) <u>Fractured dislocation cervical spine with severed cord-Sudden</u> DUE TO Antecedent cause(s) (b) <u>giving rise to the above cause</u> stating underlying cause last (c) <u>stating underlying cause last</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Highway</u>		21c. (City or town) (County) <u>Salisbury Wicomico</u>		(State) <u>Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7- 8- 55 2 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto collided with truck.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Emil H. Rye</u>		M. D. <u>Emil H. Rye</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>7-11-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7-10-55</u>		NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		LOCATION (City, town, or county) (State) <u>Berlin Md.</u>	
DATE REC'D BY LOCAL REG <u>7-14-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Anna A. Burbage, Berlin, Md.</u>		ADDRESS	

BUREAU V. S.

JUL 18 1955

RECEIVED

7188

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>12 Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Westover</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)		✓	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>MARION</u> <u>GATES</u>				<u>July 17 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>July 6, 1885</u>	9. AGE last birthday: <u>70</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>		11. BIRTHPLACE (State or foreign country): <u>Maplewood, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Albert Franklin Gates</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Herring</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY NO.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Emma Gates, Westover, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
584X IMMEDIATE CAUSE				4 days			
ANTECEDENT CAUSE (S)				4			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Peritonitis Acute</u>							
DUE TO							
(B) <u>Perforation of Gall Bladder</u>							
DUE TO							
(C) <u>Cholecystitis & cholelithiasis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Bronchial asthma</u>			
19A. DATE OF OPERATION: <u>24</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>July 15, 1955</u> to <u>July 17, 1955</u> that I last saw the deceased alive on <u>July 17, 1955</u> and that death occurred at <u>11:29</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>David J. Schure</u>		M. D. <u>Salisbury Md.</u>		DATE SIGNED <u>July 17, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>7-19-55</u>		<u>Manakin Presbyterian</u>		<u>Princess Anne, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-20-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		FUNERAL DIRECTOR <u>James Herman</u>		ADDRESS <u>Princess Anne Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 21 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE Maryland COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) Fruitland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS P. G. Hospt.				STREET ADDRESS (If rural, give location) Green Street,			
3. NAME OF DECEASED: (First) (Middle) (Last) James Francis Gordy				4. DATE OF DEATH (Month) (Day) (Year) July 29. 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Married	8. DATE OF BIRTH: April 25. 1919.	9. AGE last birthday: 36. yrs.		IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if Prop. Service Station, Gas & Oil Station.		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Hebron, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Carl F. Gordy				14. MOTHER'S MAIDEN NAME: Mary Mumford			
15. WAS DECEASED OVER 100 YEARS OLD? (Yes, no, or unk.) Yes				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Mrs. Nadine T. Gordy (Wife) Fruitland, Md.	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
976X Immediate cause (a) Bullet wound of Brain DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				20 hrs.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home		21c. (City or town) Fruitland (County) Wicomico (State) md			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 7 28 54/10 P.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Shot self - pistol			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Earl L. Lyle		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED 8-1-55	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Aug. 1. 55.		NAME OF CEMETERY OR CREMATORY Hebron, Cemetery.		LOCATION (City, town, or county) (State) Hebron, Maryland.	
DATE REC'D BY LOCAL REG. 8-2-55		REGISTRAR'S SIGNATURE Mary W. Holloway		24. FUNERAL DIRECTOR Holloway & Co. Salisbury, Maryland.		ADDRESS	

07192

RECEIVED

AUG 4 1955

BUREAU V. 8

1 **INSTRUCTIONS** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07193

7185

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>3 yr. 2 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>R. F. D. #3</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Jennie Foskey Haddock</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 29 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 18, 1883</u>	
9. AGE last birthday <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Whitesville, Delaware</u>	
13. FATHER'S NAME <u>Elijah Foskey</u>				14. MOTHER'S MAIDEN NAME <u>Annie West</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Self on admission</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
002X IMMEDIATE CAUSE (A) DUE TO ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (B) DUE TO (C) <u>Pulmonary Tuberculosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 28, 1952</u>, to <u>July 29, 1955</u>, that I last saw the deceased alive on <u>July 29, 1955</u>, and that death occurred at <u>5:15 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Lee L. Laury</u>		M. D. <u>Frederick M. B...</u>		ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>Aug. 1, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Line Church Cemetery near Whitesville, Del.</u>		LOCATION (City, town, county) (State) <u>Salisbury, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Aug. 1, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary J. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick M. B...</u>		ADDRESS <u>Salisbury, Md.</u>	

CERTIFICATE OF DEATH

FILE NO.

USUAL RESIDENCE OF DECEASED

PLACE OF DEATH

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH
 OCCUPATION
 MARITAL STATUS
 COLOR
 RELIGION
 EDUCATION
 SERVICE IN ARMED FORCES
 SOCIAL SECURITY NO.

DATE OF DEATH
 TIME OF DEATH
 PLACE OF DEATH
 CAUSE OF DEATH
 MANNER OF DEATH
 MEDICAL ATTENDANT
 PHYSICIAN
 SURGEON
 NURSE
 CORONER
 JURY

DATE OF INTERMENT
 TIME OF INTERMENT
 PLACE OF INTERMENT
 NAME OF INTERMENT SOCIETY
 NAME OF MINISTER
 NAME OF CHURCH

REGISTERED

THIS CERTIFICATE IS TO BE FILED IN THE BUREAU OF VITAL RECORDS, DEPARTMENT OF HEALTH, COMMONWEALTH OF MASSACHUSETTS, AND IN THE BUREAU OF VITAL RECORDS, COUNTY OF [COUNTY], MASSACHUSETTS. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

BUREAU VITAL

AUG 1 1955

RECEIVED

7186

Item 9, Baltimore 7-18-55 et

CERTIFICATE OF DEATH

Reg. Dist. No. 332

07194

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Pa.</u>		COUNTY <u>YORK</u>	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write OR and give nearest town)		RURAL (If rural give location)	
TOWN <u>Salisbury</u>		<u>1 DAY</u>		TOWN <u>YORK</u>		<u>75x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS <u>632 ROOSEVELT AVE.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>ERVIN</u>				<u>July 4 - 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH: <u>Dec 1, 1888</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>REFRIGERATION</u>		9. AGE last birthday <u>67</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>YORK CO, PA.</u>	
13. FATHER'S NAME: <u>Reuben Harbold</u>				14. MOTHER'S MAIDEN NAME: <u>Ellen Brulhart</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>176-01-8623</u>		17. INFORMANT & ADDRESS: <u>Mrs Erwin Harbold, Same.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial Infarct, acute</u>						<u>24 hours</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/4/1955</u> to <u>7/4/1955</u> , that I last saw the deceased alive on <u>7/4/1955</u> , and that death occurred at <u>3:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>C. Ellis</u>				DATE SIGNED <u>7-4-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>MT. ROSE CEMETERY</u>		LOCATION (City, town, or county) (State) <u>YORK, YORK CO. Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-9-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>THE HILL & JOHNSON</u>		ADDRESS <u>SALISBURY, MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 13 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07195

7187

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		STATE <i>MD</i> COUNTY <i>Wicomico</i>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <i>Salisbury Md</i>		LENGTH OF STAY (If this place)		CITY OR TOWN <i>Salisbury Md</i>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) <i>Caroline</i> (First) <i>Harmoy</i> (Middle) (Last)				4. DATE OF DEATH (Month) <i>7</i> (Day) <i>7</i> (Year) <i>1955</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>cl</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>Aug 12, 1860</i>	9. AGE last birthday <i>95</i> yrs.	IF UNDER 1 YEAR Months <i></i> Days <i></i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Frederick</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Herbert Block</i>				14. MOTHER'S MAIDEN NAME <i>Caroline Block</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Flora Harmoy</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
260X IMMEDIATE CAUSE (A) <i>Diabetes Mellitus</i>				INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>			
ANTECEDENT CAUSE(S) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>Hypertension</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Week</i>			
(C) <i>Arterio sclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Week</i>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 7, 1955</i>, to <i>July 7, 1955</i>, that I last saw the deceased alive on <i>July 7, 1955</i>, and that death occurred at <i>8:15</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>H. Herbert Doubly</i> M.D.				ADDRESS (Street, city, town, state) <i>Salisbury Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>7-10-55</i>		NAME OF CEMETERY OR CREMATORY <i>Bureau Cem.</i>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE <i>B. J. Dayton</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. G. G. G. G.</i>	
DATE <i>7-12-55</i>				ADDRESS			

TO THE HONORABLE MEMBERS OF THE HOUSE OF REPRESENTATIVES
OF THE STATE OF NEW YORK
IN SENATE, JANUARY 18, 1890.
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1889.
ALBANY: J. B. LEECH, STATE PRINTER.
1890.

100

James
Stewart
Hickford

BUREAU V. S.

12 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07196

7188

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>2 wks</u>		TOWN <u>Eden</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Jacob</u> (Middle) <u>Earl</u> (Last) <u>Harmon</u>				(Month) <u>July</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>1899</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Saw Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Eden, Somerset Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Harmon</u>				14. MOTHER'S MAIDEN NAME <u>Laura Hudson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-20-7575</u>		17. INFORMANT & ADDRESS <u>Mrs. Maggie Harmon, Eden, Md Rte 1</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>002X Empyema, left Thorax</u>				INTERVAL BETWEEN ONSET AND DEATH <u>approx 2 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>(Cause unknown)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Pulmonary Tuberculosis, left apex</u>							
19. DATE OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/16</u> , 19 <u>55</u> , to <u>7/29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/29</u> , 19 <u>55</u> , and that death occurred at <u>3:30 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>David Schure</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>July 30, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-2-55</u>		NAME OF CEMETERY OR CREMATORY <u>Flower Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Eden, Somerset Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary K. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mary A. Stewart</u>		ADDRESS <u>324 E. Church St. Salisbury, Md.</u>	
DATE <u>Aug. 2, 1955</u>							

CERTIFICATE OF DEATH

Date of Death

Place of Death

DECEASED

Place of Birth

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF INCINERATION

NAME OF DISSECTION

NAME OF ANATOMY

NAME OF PATHOLOGY

NAME OF RADIOLOGY

NAME OF CHEMISTRY

NAME OF PHYSIOLOGY

NAME OF ANATOMY

NAME OF PATHOLOGY

NAME OF RADIOLOGY

NAME OF CHEMISTRY

NAME OF PHYSIOLOGY

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NAME OF RADIOLOGY

NAME OF CHEMISTRY

NAME OF PHYSIOLOGY

NAME OF ANATOMY

NAME OF PATHOLOGY

NAME OF RADIOLOGY

BUREAU V. 1

AUG 2, 1955

100-1510

7189

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>120 SNLISBURY</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Snow Hill</u> <u>23X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print) <u>MELARIE GAIL HARRIS</u>		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>July 16 1955</u>			
5. SEX: <u>7</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>N.B.</u>		8. DATE OF BIRTH: <u>7-15-55</u>	
9. AGE last birthday <u>7</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>4 43</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Bobbie Lee Harris</u>		14. MOTHER'S MAIDEN NAME: <u>Christine Lewis</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.):		16. SOCIAL SECURITY NO.:	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.):		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS: <u>Mrs. Allie Carter, Snow Hill, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
762.5 IMMEDIATE CAUSE (A) <u>atelectasis</u>							
ANTECEDENT CAUSE (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at <u>7:45</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>W. C. Morgan</u>				ADDRESS <u>M.D. Salisbury Md</u>		DATE SIGNED <u>7/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>7-16-55</u>		NAME OF CEMETERY OR CREMATORY <u>Whateoat Methodist Cemetery Snow Hill, Md</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>7-18-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Clay E. Dennis, Snow Hill, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 20 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 322

No. 260

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Florida</u>		COUNTY <u>De Soto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
12 TOWN <u>Salisbury</u>		<u>1 hour</u>		TOWN <u>Arcadia</u>		<u>48X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsular General Hosp.</u>				STREET ADDRESS (If rural, give location) <u>611 Bond</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Edward J. Hartfield Jr.</u>				<u>July 6 1950</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>March 18, 1950</u>	
9. AGE last birthday: <u>5</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Florida</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Edward Hartfield</u>				14. MOTHER'S MAIDEN NAME: <u>Christine Gunner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No.: <u>—</u>			
17. INFORMANT & ADDRESS: <u>Hartfield Arcadia Fla.</u>				18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
830X Immediate cause (a) <u>Internal Hemorrhage - Shock</u>						<u>2 hours</u>	
Antecedent cause(s) (b) <u>Ruptured Abdominal Visera</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Was asleep in Bean field - run over by truck</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Field</u>		21c. (City or town) (County) (State) <u>Weston P. O. Sumner Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>July 6-55 5:10 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Run over by truck while asleep in Bean field.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>R.D. Johnson</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>July 8-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>7-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Arcadia Fla.</u>	
DATE REC'D BY LOCAL REG. <u>7/8/55</u>		REGISTRAR'S SIGNATURE <u>R.D. Johnson</u>		24. FUNERAL DIRECTOR <u>M. H. Williams</u>		ADDRESS <u>James J. Brown, Jr.</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED

JUL 11 1955

BUREAU V. S.

ORIGINAL NOT TO BE DESTROYED

This form will only be used in cases where the death is reported to the Registrar of Vital Statistics by a physician or other person authorized to report deaths. It is not to be used in cases where the death is reported to the Registrar by a family member or other person not authorized to report deaths. In such cases, the death should be reported on the form provided for that purpose.

DEATH CERTIFICATE (To be filled out by the Medical Examiner)		DEATH CERTIFICATE (To be filled out by the Registrar)	
NAME OF DECEASED (Print name in full)		SEX (Male or Female)	
DATE OF DEATH (Month, Day, Year)		TIME OF DEATH (Hour, Minute)	
PLACE OF DEATH (City, Town, or Village)		COUNTY (Name of County)	
OCCUPATION (If any)		CAUSE OF DEATH (If known)	
MANNER OF DEATH (Natural, Accidental, or Suicidal)		MEDICAL EXAMINER'S SIGNATURE (Print name and title)	
REGISTERAR'S SIGNATURE (Print name and title)		OFFICIAL SEAL (If applicable)	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07199

7191

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Salisbury, Maryland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Salisbury, Maryland</u>	
TOWN <u>Salisbury, Maryland</u>		<u>2 mo. 25 days</u>		TOWN <u>Salisbury, Maryland</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>P.O. Box 762</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Kearney</u> (Middle) <u>Crescent</u> (Last) <u>Hitch</u>				(Month) <u>July</u> (Day) <u>10</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Dec. 10, 1880</u>	
9. AGE last birthday <u>74</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Parking Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>Wilmington, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dr. Thomas A. Hitch</u>				14. MOTHER'S MAIDEN NAME <u>Almira Daisey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk Yes</u> (If Yes, give war or dates of service) <u>W.W. # 1</u>				16. SOCIAL SECURITY NO. <u>215-18-4736</u>		17. INFORMANT & ADDRESS <u>Hospital Records & Mrs. Margaret Tatman - Box 234 Lincoln Delaware (No Relation)</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovasclar Disease</u>				unk			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 15, 19 55</u> , to <u>July 10, 19 55</u> , that I last saw the deceased alive on <u>July 10, 19 55</u> , and that death occurred at <u>7:15 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>M. Haldane</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>7/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary Hallaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
DATE <u>July 14, 1955</u>							

CERTIFICATE OF DEATH

Form 10-1-55

1. USUAL RESIDENCE (House or Hospital)

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEAREST RELATIVE

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF DECEASED

21. SIGNATURE OF NEAREST RELATIVE

22. SIGNATURE OF CLERGYMAN

23. SIGNATURE OF BURIAL OFFICIAL

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF DECEASED

26. SIGNATURE OF NEAREST RELATIVE

27. SIGNATURE OF CLERGYMAN

28. SIGNATURE OF BURIAL OFFICIAL

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF DECEASED

31. SIGNATURE OF NEAREST RELATIVE

32. SIGNATURE OF CLERGYMAN

33. SIGNATURE OF BURIAL OFFICIAL

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF DECEASED

36. SIGNATURE OF NEAREST RELATIVE

37. SIGNATURE OF CLERGYMAN

38. SIGNATURE OF BURIAL OFFICIAL

39. SIGNATURE OF INTERVIEWER

40. SIGNATURE OF DECEASED

41. SIGNATURE OF NEAREST RELATIVE

42. SIGNATURE OF CLERGYMAN

43. SIGNATURE OF BURIAL OFFICIAL

44. SIGNATURE OF INTERVIEWER

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF DEATH

TIME OF DEATH

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

SIGNATURE OF WITNESSES

SIGNATURE OF DECEASED

SIGNATURE OF NEAREST RELATIVE

SIGNATURE OF CLERGYMAN

SIGNATURE OF BURIAL OFFICIAL

SIGNATURE OF INTERVIEWER

SIGNATURE OF DECEASED

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SIGNATURE OF INTERVIEWER

SIGNATURE OF DECEASED

SIGNATURE OF NEAREST RELATIVE

SIGNATURE OF CLERGYMAN

SIGNATURE OF BURIAL OFFICIAL

SIGNATURE OF INTERVIEWER

1. USUAL RESIDENCE (House or Hospital)

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEAREST RELATIVE

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF DECEASED

21. SIGNATURE OF NEAREST RELATIVE

22. SIGNATURE OF CLERGYMAN

23. SIGNATURE OF BURIAL OFFICIAL

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF DECEASED

26. SIGNATURE OF NEAREST RELATIVE

27. SIGNATURE OF CLERGYMAN

28. SIGNATURE OF BURIAL OFFICIAL

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF DECEASED

31. SIGNATURE OF NEAREST RELATIVE

32. SIGNATURE OF CLERGYMAN

33. SIGNATURE OF BURIAL OFFICIAL

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF DECEASED

36. SIGNATURE OF NEAREST RELATIVE

37. SIGNATURE OF CLERGYMAN

38. SIGNATURE OF BURIAL OFFICIAL

39. SIGNATURE OF INTERVIEWER

40. SIGNATURE OF DECEASED

41. SIGNATURE OF NEAREST RELATIVE

42. SIGNATURE OF CLERGYMAN

43. SIGNATURE OF BURIAL OFFICIAL

44. SIGNATURE OF INTERVIEWER

1. USUAL RESIDENCE (House or Hospital)

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEAREST RELATIVE

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF DECEASED

21. SIGNATURE OF NEAREST RELATIVE

22. SIGNATURE OF CLERGYMAN

23. SIGNATURE OF BURIAL OFFICIAL

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF DECEASED

26. SIGNATURE OF NEAREST RELATIVE

27. SIGNATURE OF CLERGYMAN

28. SIGNATURE OF BURIAL OFFICIAL

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF DECEASED

31. SIGNATURE OF NEAREST RELATIVE

32. SIGNATURE OF CLERGYMAN

33. SIGNATURE OF BURIAL OFFICIAL

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF DECEASED

36. SIGNATURE OF NEAREST RELATIVE

37. SIGNATURE OF CLERGYMAN

38. SIGNATURE OF BURIAL OFFICIAL

39. SIGNATURE OF INTERVIEWER

40. SIGNATURE OF DECEASED

41. SIGNATURE OF NEAREST RELATIVE

42. SIGNATURE OF CLERGYMAN

43. SIGNATURE OF BURIAL OFFICIAL

44. SIGNATURE OF INTERVIEWER

BUREAU VI

1955

RECEIVED

RECORDS SECTION

1955

1955

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1 hours after death.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

7192

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07200

CERTIFICATE OF DEATH

Dr. Burton & Mitchell

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		TOWN Salisbury	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 208 Race St				STREET ADDRESS 208 Race St.		(If rural give location)	
3. NAME OF DECEASED (Type or Print) WILMER (First) JOHNSON (Middle) HOBBS (Last)				4. DATE OF DEATH July 20 th 19 55			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH April 8, 1877	
9. AGE last birthday 78 yrs.		IF UNDER 1 YEAR Months 4 Days 12		IF UNDER 24 HRS. Hours 12 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer for City		10b. KIND OF BUSINESS OR INDUSTRY Street Dept.		11. BIRTHPLACE (State or foreign country) Waltons Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elijah Hobbs				14. MOTHER'S MAIDEN NAME Sarah Jane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Jonette Harmon (Daughter) 309 Quincy St Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) Arterio-sclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) Cerebro Vascular accident							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 5/10 , 19 54 , to 7/12 , 19 55 , that I last saw the deceased alive on 7/12 , 19 55 , and that death occurred at 7/12 , M, from the causes and on the date stated above.							
SIGNATURE J C Mitchell				ADDRESS (Street, city, town, state) DATE SIGNED M.D. Maryland Ave. Salisbury, Maryland July 22 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 23, 1955		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR DATE 7-25-55		REGISTRAR'S SIGNATURE Mary D. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	

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Visit us online

8481, 25 July 1973

PLATYCEPHALUS - TETRAPOD & TACONION

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07201

7227

CERTIFICATE OF DEATH

Reg. Dist. No. 732

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Wicomico</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Pantego</i>		<i>Life time</i>		TOWN <i>Pantego</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>Spry D. Horner</i>				<i>7-6-55</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>M</i>	<i>W</i>	<i>Married</i>	<i>5-25-88</i>	<i>70</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Farmer</i>		<i>Own Farm</i>		<i>Birchville, Md.</i>		<i>U.S.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Levin Horner</i>				<i>Amanda Horner</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>Not</i>		<i>212-12-3965</i>		<i>Mae Horner, Pantego, Maryland</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
237X IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<i>Cerebral Tumor.</i>				<i>3 years.</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<i>Transition.</i>				<i>1 month.</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>11/5</i> , 19 <i>48</i> , to <i>7/6</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>7/6</i> , 19 <i>55</i> , and that death occurred at <i>10:55 PM</i> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>D. H. Saunders</i>				<i>Pantego Md.</i>		<i>7/8/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<i>Burial</i>		<i>7/9/55</i>		<i>Birchville Cemetery</i>		<i>Birchville, Maryland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>July 7, 1955</i>		<i>B. J. Wayton</i>		<i>Wm. H. P. Pessier</i>		<i>Birchville, Maryland</i>	

RECEIVED

JUL 11 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

7193

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07202

CERTIFICATE OF DEATH

Item 9. FilmG184 7-28-55 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>302 Midland Ave; Patapsco Pk.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Minnie</u> (Middle) (Last) <u>Horshaw</u>				(Month) <u>July</u> (Day) <u>18</u> (Year) <u>55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 3, 1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Luckus</u>				14. MOTHER'S MAIDEN NAME <u>Evilymine Reed</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unk</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
332X IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic cardiovascular disease</u>						?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 23, 1951</u> , to <u>July 18, 1955</u> , that I last saw the deceased alive on <u>July 18, 1955</u> , and that death occurred at <u>2:50P</u> M., from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>		L.V. Maldve, M.D. M.D. <u>Deer's Head Hospital; Salisbury, Md.</u>		ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>7/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Auburn Ct</u>		LOCATION (City, town, or county) (State) <u>Baltimore, City</u>	
24. REC'D BY REGISTRAR <u>1-25-55</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Isaiah L Brown</u>		ADDRESS <u>108 W Montgomery Street</u>	

CERTIFICATE OF DEATH

Form No. 100-1

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Signature of registrar

9. Signature of informant

10. Date of registration

11. Place of registration

12. Signature of registrar

13. Date of registration

14. Place of registration

15. Signature of registrar

16. Date of registration

17. Place of registration

18. Signature of registrar

19. Date of registration

20. Place of registration

21. Signature of registrar

22. Date of registration

23. Place of registration

24. Signature of registrar

25. Date of registration

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121. Date of registration

122. Place of registration

123. Signature of registrar

124. Date of registration

125. Place of registration

126. Signature of registrar

127. Date of registration

128. Place of registration

129. Signature of registrar

130. Date of registration

BUREAU

JUL 25

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7194

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07203

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
12 <u>Salisbury</u>		1 <u>Week</u>		Snow Hill		23X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>Perinatal General Hospital</u>							
3. NAME OF DECEASED:			4. DATE (Month) (Day) (Year)				
(First) (Middle) (Last)			OF DEATH: July 2 - 1955				
5. SEX: <u>Male</u>			6. COLOR OR RACE: <u>White</u>			7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	
8. DATE OF BIRTH: <u>Aug. 6, 1862</u>			9. AGE last birthday <u>92</u> yrs.			IF UNDER 1 YEAR: Months <u>10</u> Days <u>26</u> Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
<u>Farmer</u>		<u>Farming</u>		<u>Stockton, Md</u>		<u>USA</u>	
13. FATHER'S NAME: <u>Samuel Hudson</u>				14. MOTHER'S MAIDEN NAME: <u>Mary E. Hudson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>none</u>		<u>Mrs Mary H. Townsend, Snow Hill Md</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE		(A) <u>Her go state pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH		<u>2 days</u>	
ANTECEDENT CAUSE (S)		(B) <u>Generalized arteriosclerosis</u>				<u>underlying</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>Diabetes mellitus</u>				<u>1</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/25, 1953</u> to <u>7/2</u> , 1955 that I last saw the deceased alive on <u>7/2</u> , 1955, and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>William R. Ellis, Jr.</u>		<u>Salisbury, Md</u>		<u>7-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-5-55</u>		<u>Episcopal Cemetery</u>		<u>Snow Hill, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-5-55</u>		<u>Mary W. Holloway</u>		<u>Clay E. Dennis, Snow Hill, Md.</u>			

RECEIVED
JUL 7 1935
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>VIRGINIA</u>	COUNTY <u>Accomac</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
TOWN <u>SALISBURY</u>	<u>1 1/2 HOUR</u>	TOWN <u>NEW CHURCH</u>	<u>83X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First)	(Middle)	(Last)	
<u>HENRY</u>	<u>S.</u>	<u>HURLEY Jr</u>	DATE: <u>July 25</u> 19 <u>55</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>MALE</u>	<u>WHITE</u>		<u>Dec. 19, 1883</u>
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>71</u> yrs.	Months <u>6</u> Days <u>6</u> Hours <u></u> Min. <u></u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country):
<u>Retired Farmer</u>		<u>Owned own Farm</u>	<u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY?			
<u>USA</u>			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Henry S Hurley</u>		<u>Julia Ann Hall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>4th</u> <u>no</u>		<u>none</u>	
17. INFORMANT & ADDRESS:			
<u>Mrs. Willie Mae Hurley New Church Pa</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A)			<u>4 hrs.</u>
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<u>Acute Pulmonary Edema</u>			<u>3 hrs.</u>
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<u>21</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 25, 1955</u> to <u>July 25, 1955</u> , that I last saw the deceased alive on <u>July 25, 1955</u> and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Harold J. Selmon</u>		DATE SIGNED <u>July 26, 1955</u>	
M. D. <u>Salisbury Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	<u>7-28-55</u>	<u>Salem, M.E. Cemetery</u>	<u>Pocomoke, Md</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>7-26-55</u>	<u>Mary W. Holloway</u>	<u>Henry S. Watson</u>	<u>Pocomoke Md.</u>

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUL 28 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-5C 1-5S 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07205

7196

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury		Most of life		TOWN Salisbury		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 112 Catherine Street				STREET ADDRESS (If rural give location) 112 Catherine Street			
3. NAME OF DECEASED (First) (Middle) (Last) Viola Elizabeth Jackson				4. DATE OF DEATH (Month) (Day) (Year) 7 - 13 - 19 55			
5. SEX Female	6. COLOR OR RACE A.A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 1-27-1904	9. AGE last birthday 51 yrs.	IF UNDER 1 YEAR Months 5 Days 16	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafe/teria		10b. KIND OF BUSINESS OR INDUSTRY Cambell Soup Co.		11. BIRTHPLACE (State or foreign country) Salisbury, Wicomico Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Jackson				14. MOTHER'S MAIDEN NAME Elenora Messick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 217-09-6853		17. INFORMANT & ADDRESS Salisbury, Md. Mrs. Nellie Nichols, 332 Lake Street			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
157X IMMEDIATE CAUSE (A) Carcinoma Head of Pancreas						INTERVAL BETWEEN ONSET AND DEATH undetermined	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 27, 1954, to July 13, 1955, that I last saw the deceased alive on July 13, 1955, and that death occurred at 11:35 P.M. from the causes and on the date stated above.							
SIGNATURE E. A. Purnell		ADDRESS (Street, city, town, state) 652 W. Main St., Salisbury, Md.		DATE SIGNED July 15, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-17-55		NAME OF CEMETERY OR CREMATORY Green Acres Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Wicomico Co. Md.	
24. REC'D BY REGISTRAR Mary Dr. H. L. Lomas		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE Mary A. Stewart		ADDRESS 324 E. Church Street Salisbury, Maryland	
DATE July 18, 1955							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

FILE NO. 100-100000

LOCAL RESIDENTS OF BALTIMORE

NAME: **James Jackson**

RESIDENCE: **112 Chestnut Street**

CITY: **Baltimore**

DATE OF BIRTH: **1-27-1904**

DATE OF DEATH: **1-28-1904**

PLACE OF BIRTH: **112 Chestnut Street**

PLACE OF DEATH: **112 Chestnut Street**

CAUSE OF DEATH: **Violence**

MANNER OF DEATH: **Violence**

SEX: **Male**

AGE: **37**

DATE OF BIRTH: **1-27-1904**

DATE OF DEATH: **1-28-1904**

SEX: **Male**

PLACE OF BIRTH: **112 Chestnut Street**

PLACE OF DEATH: **112 Chestnut Street**

CAUSE OF DEATH: **Violence**

MANNER OF DEATH: **Violence**

NAME: **James Jackson**

RESIDENCE: **112 Chestnut Street**

CITY: **Baltimore**

BUREAU V. 2

FILE NO. 100-100000

FILE NO. 100-100000

NAME: **James Jackson**

RESIDENCE: **112 Chestnut Street**

CITY: **Baltimore**

CERTIFICATE OF DEATH

Reg. Dist. No. 237

7197

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY OR TOWN		(If rural give location)	
12 TOWN Salisbury				Pittsville, P. O.		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
81 Peninsula General Hospital				/			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Mattie (Middle) H. (Last) Jacobs				(Month) 7 (Day) 24 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	A.A.	Married	2-12-05	50 yrs.	Months 5	Days 12	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farm Work		Seasonal		Wadley, Georgia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Millard Powell				Ola - Powell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		No		James Jacobs, Pittsville, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						5/28/55	
331X IMMEDIATE CAUSE (A) Cerebromalacia and bronchopneumonia							
ANTECEDENT CAUSE(S) DUE TO Subdural hematoma						to	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)						7/23/55	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
5/28/55		Massive subdural hematoma, right.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		22	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
5 28 1955 M.		White at work Not while at work		Auto Accident			
22. I hereby certify that I attended the deceased from 5/28/55, 19....., to 7/6/55, 19....., that I last saw the deceased alive on 7/23/55, 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE <i>Walter H. Stewart</i>				M.D. Salisbury, Md.		DATE SIGNED 7/26/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-27-55		Green Acres Memorial Park		Salisbury, Wicomico Co., Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE July 28, 1955		<i>Mary H. Holloway</i>		<i>Mary A. Stewart</i>		324 E. Church St Salisbury, Md.	

INSTRUCTIONS

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1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

NAME OF DECEASED: **William Henry**
 PLACE OF DEATH: **Salisbury**
 COUNTY: **Washington**
 CITY: **Washington, D. C.**

DATE OF DEATH: **July 28, 1955**
 TIME OF DEATH: **10:00 AM**
 PLACE OF DEATH: **Green Acres Memorial Park, Salisbury**

CAUSE OF DEATH: **Heart Disease**
 MANNER OF DEATH: **Natural**
 SEX: **Male**
 AGE: **70**

DATE OF BIRTH: **July 10, 1885**
 PLACE OF BIRTH: **Washington, D. C.**
 SEX: **Male**
 AGE: **70**

DATE OF DEATH: **July 28, 1955**
 TIME OF DEATH: **10:00 AM**
 PLACE OF DEATH: **Green Acres Memorial Park, Salisbury**

CAUSE OF DEATH: **Heart Disease**
 MANNER OF DEATH: **Natural**
 SEX: **Male**
 AGE: **70**

DATE OF BIRTH: **July 10, 1885**
 PLACE OF BIRTH: **Washington, D. C.**
 SEX: **Male**
 AGE: **70**

DATE OF DEATH: **July 28, 1955**
 TIME OF DEATH: **10:00 AM**
 PLACE OF DEATH: **Green Acres Memorial Park, Salisbury**

CAUSE OF DEATH: **Heart Disease**
 MANNER OF DEATH: **Natural**
 SEX: **Male**
 AGE: **70**

RECEIVED
BUREAU V. 51
JUL 28 1955

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7198

CERTIFICATE OF DEATH

07207

Reg. Dist. No. 382

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>12</u> TOWN <u>Salisbury, Maryland</u>		<u>5</u> mo.		TOWN <u>Greensboro, Maryland</u>		<u>05X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>91</u> <u>Deer's Head State Hospital</u>				<u>Railroad Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Harry B. Jarman</u>				<u>July 17, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>May 22, 1892</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>unk</u>		<u>unk</u>		<u>Caroline County, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert E. Jarman</u>				<u>Clara Barcus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>213-91-7110</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>162X</u> IMMEDIATE CAUSE (A) <u>Massive Pulmonary hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 Min</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Branchogenic Ca of lung</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 18, 1955</u>, to <u>July 17, 1955</u>, that I last saw the deceased alive on <u>July 17, 1955</u>, and that death occurred at <u>10:50A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>7/17/55</u>			
				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/19/55</u>		<u>Greensboro</u>		<u>Greensboro Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>7/19/55</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>Greensboro Md.</u>	

CERTIFICATE OF DEATH

1955

ATTEST: REGISTERED DEATHS ON EACH SIDE

NAME OF DECEASED JAMES P. HENRY	DATE OF BIRTH JAN 15 1900	PLACE OF BIRTH NEW YORK	DATE OF DEATH JUL 15 1955	PLACE OF DEATH BALTIMORE
SEX MALE	AGE 55	MARRIAGE MARRIED	CAUSE OF DEATH HEART DISEASE	DIAGNOSIS CORONARY ARTERY DISEASE
SIGNATURE OF DECEASED JAMES P. HENRY				
SIGNATURE OF NEXT OF KIN JAMES P. HENRY				
SIGNATURE OF PHYSICIAN JAMES P. HENRY				
SIGNATURE OF REGISTRAR JAMES P. HENRY				

DATE OF BIRTH JAN 15 1900	PLACE OF BIRTH NEW YORK	DATE OF DEATH JUL 15 1955	PLACE OF DEATH BALTIMORE
SEX MALE	AGE 55	MARRIAGE MARRIED	CAUSE OF DEATH HEART DISEASE
DIAGNOSIS CORONARY ARTERY DISEASE			
SIGNATURE OF DECEASED JAMES P. HENRY			
SIGNATURE OF NEXT OF KIN JAMES P. HENRY			
SIGNATURE OF PHYSICIAN JAMES P. HENRY			
SIGNATURE OF REGISTRAR JAMES P. HENRY			

BUREAU V. 2

JUL 20 1955

RECEIVED

James P. Henry
JAMES P. HENRY

ENCLOSURE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Salisbury</u>		<u>life</u>		TOWN <u>Salisbury</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural, give location) <u>601 D Westover Drive</u>			
3. NAME OF DECEASED: (First) <u>Henry</u>		(Middle) <u>Edward</u>		(Last) <u>Johnson</u>		4. DATE OF DEATH (Month) <u>7</u> (Day) <u>19</u> (Year) <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>4-28-31</u>	9. AGE last birthday: <u>24</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Police</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Wicomico Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Robert Harris</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>713-22-9621</u>		17. INFORMANT & ADDRESS: <u>Shelma C. Johnson</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>982X</u> Immediate cause (a) <u>Stab wound of heart.</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>5 hours.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>		21c. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Maryland</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>7</u> <u>18</u> <u>55</u> <u>11:30</u> PM		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Stabbed in fight.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Emil L. Ryan</u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7-22-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>7-26-55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. View Cem.</u>		LOCATION (City, town, or county) <u>Wicomico Co. Md.</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>7-25-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR <u>Booker M. West</u>		ADDRESS	

7199

122, 11 Fim G-191 1-19-56 EIT

07208

RECEIVED

JUL 27 1955

BUREAU V. S.

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07209

7200

CERTIFICATE OF DEATH

Reg. Dist. No. 382

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury		2 mons.		TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 604 Camden Ave.				STREET ADDRESS (If rural give location) 604 Camden Ave.			
3. NAME OF DECEASED (Type or Print) CLAUDE OWENS KELL				4. DATE OF DEATH (Month) 7 (Day) 5 (Year) 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 27, 1892	9. AGE last birthday 62 yrs.	IF UNDER 1 YEAR Months 7 Days 5	IF UNDER 24 HRS. Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY E. D. O.		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander Kell				14. MOTHER'S MAIDEN NAME Emma Erwin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) YES		16. SOCIAL SECURITY NO. 234-50-0068		17. INFORMANT & ADDRESS Mrs. Clara P. Kell same			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Coronary Occlusion				INTERVAL BETWEEN ONSET AND DEATH Sudden			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/5/55, 1955, to 7/7/55, 1955, that I last saw the deceased alive on 7/5/55, 1955, and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
SIGNATURE Frederic R. Deane				ADDRESS (Street, city, town, state) Salisbury, Md.			
DATE SIGNED 7/7/55							
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 7/8/1955		NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		LOCATION (City, town, or county) Arlington, VA.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE B. J. Rayton		25. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co. Salisbury, Md.			
DATE July 7, 1955							

George C. Hill, II

1

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07210

7201

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury		LENGTH OF STAY (in this place) About 12 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 82 Peninsula General Hospital				STREET ADDRESS (If rural give location) Willow Street			
3. NAME OF DECEASED (Type or Print) Clara Kerney				4. DATE OF DEATH (Month) (Day) (Year) 7 - 5 - 1955			
5. SEX Female	6. COLOR OR RACE A.A.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 1896		9. AGE last birthday 59 yrs.		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY Star Laundry		11. BIRTHPLACE (State or foreign country) Guyton, Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Reese				14. MOTHER'S MAIDEN NAME Maggie Hines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 253-16-2533 A		17. INFORMANT & ADDRESS Mrs. Ida Fleming, Savannah, Georgia			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) Acute Carditis						INTERVAL BETWEEN ONSET AND DEATH 1 Hour	
ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Heart Disease						Unk.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) -----							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. -----							
19a. DATE OF OPERATION -----		19b. MAJOR FINDINGS OF OPERATION -----				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) -----		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) -----			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) -----		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? -----			
22. I hereby certify that I attended the deceased from June 26, 1955, to July 5, 1955, that I last saw the deceased alive on July 5, 1955, and that death occurred at 9:28 P.M. the causes and on the date stated above.							
SIGNATURE <i>H. Herbert Semble</i>				ADDRESS (Street, city, town, state) Salisbury, Wicomico Maryland		DATE SIGNED 7/5/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-11-55		NAME OF CEMETERY OR CREMATOR Ferguson Cemetery		LOCATION (City, town, or county) (State) Guyton, Georgia	
24. REC'D BY REGISTRAR DATE July 11, 1955		REGISTRAR'S SIGNATURE <i>B. J. Dayton</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. Mary A. Stewart</i>		ADDRESS 324 E. Church St. Salisbury, Maryland	

CERTIFICATE OF DEATH

LOCALITY OF BIRTH		COUNTY		LOCALITY OF DEATH		COUNTY	
Boston		Suffolk		Boston		Suffolk	
NAME OF DECEASED		AGE		SEX		RACE	
John A. Smith		45		Male		White	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
July 10, 1965		Home		Heart Disease		Natural	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
July 11, 1965		July 11, 1965		July 11, 1965		July 11, 1965	

BUREAU V. 2
RECEIVED
 JUL 11 1965

SMOKELESS

INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07211

7212

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 105 W. Philadelphia Ave.				STREET ADDRESS (If rural give location) 105 W. Philadelphia Ave.			
3. NAME OF DECEASED (First) (Middle) (Last) Esther Amelia Livengood				4. DATE OF DEATH (Month) (Day) (Year) July 18. 1955.			
5. SEX Female	6. COLOR OR RACE White	7. MARRIAGE Widow	8. DATE OF BIRTH Aug. 2. 1900	9. AGE last birthday 54. yrs.	IF UNDER 1 YEAR Months 11 Days 10	IF UNDER 24 HRS. Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At own home.		11. BIRTHPLACE (State or foreign country) Bivalve, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Henry Larnore				14. MOTHER'S MAIDEN NAME Annie Insley (Daughter)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Elizabeth Livengood Derickson 105 W. Phila. Ave, Salisbury, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
195X IMMEDIATE CAUSE (A) Carcinoma of Adrenal Gland (c)				INTERVAL BETWEEN ONSET AND DEATH 1Y + App.			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 1-25-1955		19b. MAJOR FINDINGS OF OPERATION Above		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-22-1955, to 7-18-1955, that I last saw the deceased alive on 7-18-1955, and that death occurred at 9:10 P.M. from the causes and on the date stated above.							
SIGNATURE John M. Bledsoe III				ADDRESS (Street, city, town, state) Salisbury, Md.			
DATE SIGNED 7-19-55				DATE SIGNED 7-19-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 22. 55.		NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		LOCATION (City, town, or county) (State) Philadelphia, Pa.	
24. REC'D BY REGISTRAR DATE 7-25-55		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE Holloway Company, Salisbury, Maryland.			

CERTIFICATE OF DEATH

PLACE OF DEATH Baltimore		COUNTY Baltimore	
SEX Male		RACE White	
DATE OF DEATH July 18, 1955		TIME OF DEATH 11:15 AM	
PLACE OF BIRTH 105 W. Philadelphia Ave. Baltimore, Md.		PLACE OF DEATH 105 W. Philadelphia Ave. Baltimore, Md.	
NAME OF DECEASED George Henry Lawrence		NAME OF DECEASED Annie Lacey	
AGE 61		AGE 64	
OCCUPATION Retired		OCCUPATION Housewife	
CAUSE OF DEATH At own home		CAUSE OF DEATH At own home	
SIGNATURE OF PHYSICIAN (Signature)		SIGNATURE OF PHYSICIAN (Signature)	
SIGNATURE OF CORONER (Signature)		SIGNATURE OF CORONER (Signature)	
SIGNATURE OF DEATH REGISTRAR (Signature)		SIGNATURE OF DEATH REGISTRAR (Signature)	

BUREAU V. S.

JUL 25 1955

RECEIVED

Baltimore, Maryland

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7203

CERTIFICATE OF DEATH

08207

Reg. Dist. No. 332

Item 9, Film G185 8-31-55 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicomico</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Brooklyn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>		STREET ADDRESS (If rural give location) <u>3V01-4</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Nellie</u> <u>McAllister</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July</u> <u>13</u> 19 <u>55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>?</u>
9. AGE last birthday <u>Est. 75</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>?</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk.</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis Dowellson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah McClemy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>- -</u>	
17. INFORMANT & ADDRESS <u>Hospital records</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>491X</u> IMMEDIATE CAUSE (A) <u>Bronchopneumonia, right lower lobe</u>		<u>48 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) _____			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis, general</u>		<u>?</u>	
19a. DATE OF OPERATION <u>- -</u>		19b. MAJOR FINDINGS OF OPERATION <u>- -</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>- -</u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>- -</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>- -</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21f. HOW DID INJURY OCCUR? <u>- -</u>			
22. I hereby certify that I attended the deceased from <u>April 1, 1952</u> , to <u>July 13, 1955</u> , that I last saw the deceased alive on <u>July 13, 1955</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>L. V. Maldve</u>		DATE SIGNED <u>7/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>7-15-55</u>	
24. REC'D BY REGISTRAR <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. Welch</u>	
DATE <u>Aug. 24, 1955</u>		ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>	

08207

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

Form No. 10

1. LEGAL RESIDENCE (HOUSE OR DWELLING)

DATE

PLACE

TIME

BY

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BUREAU Y. B.

AUG 24 1955

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INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

7228

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

07212 237

Dr. Lambdin

Reg. Dist. No. 237

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) R.D.# 3 Mt. Hermon Rd			
3. NAME OF DECEASED (First) MARY (Middle) ELOISE (Last) MORRISON				4. DATE OF DEATH (Month) JULY (Day) 27 (Year) 19 55			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Baby	8. DATE OF BIRTH July 27, 1955	9. AGE last birthday 0 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 4 Min. 33	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pen. Gen. Hosp. Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John P. Morrison				14. MOTHER'S MAIDEN NAME Alberta Layton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. John P. Morrison (Father) R.D.# 3 Mt. Hermon Rd. Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
776X IMMEDIATE CAUSE (A) Prematurity				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 11:48P.		21a. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9 PM, 19 7-27, to 7-27, 19 55, that I last saw the deceased alive on 7-27, 19 55, and that death occurred at 11:48P. M, from the causes and on the date stated above.							
SIGNATURE Morris A. Lambdin				ADDRESS (Street, city, town, state) Camden Ave. Salisbury, Maryland July 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 29, 1955		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR Aug. 1, 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH-BUREAU OF VITAL STATISTICS

Dr. J. J. J. J.

REPORT ON DEATH

NAME: John F. Morrison

DATE OF BIRTH: July 22, 1922

PLACE OF BIRTH: New York City

PLACE OF BIRTH: New York City

PLACE OF DEATH: New York City

PLACE OF DEATH: New York City

SEX: Male

SEX: Male

SEX: Male

SEX: Male

CAUSE OF DEATH: Heart Disease

CAUSE OF DEATH: Heart Disease

CAUSE OF DEATH: Heart Disease

CAUSE OF DEATH: Heart Disease

CAUSE OF DEATH: Heart Disease

CAUSE OF DEATH: Heart Disease

CAUSE OF DEATH: Heart Disease

NAME OF DECEASED: John F. Morrison

NAME OF DECEASED: John F. Morrison

NAME OF DECEASED: John F. Morrison

BUREAU V. S.

AUG 1 1955

RECEIVED

HOLBROOK & COMPANY

RECEIVED

07213

MARYLAND

STATE DEPARTMENT OF HEALTH

7204

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Whaleynelle</u> 23X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) <u>Frank</u> (First) (Middle) <u>Niblett</u> (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>July 20 1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 26 1874</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
13. FATHER'S NAME <u>Henry Niblett</u>		14. MOTHER'S MAIDEN NAME <u>---</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>222-14-2342</u>	
		17. INFORMANT AND ADDRESS <u>Lester Niblett Whaleynelle</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0
Immediate cause (a) Generalized Peritonitis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 7/7, 1950, to 7/20, 1950, that I last saw the deceased

alive on 7/29, 1950, and that death occurred at 1:05 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frederick G. Francis, M.D. ADDRESS Salisbury, Md. DATE SIGNED 7/20/50

23. REMOVAL (Specify) <u>Reburied</u>	DATE <u>July 23, 1950</u>	NAME OF CEMETERY OR CREMATORY <u>St. John's</u>	LOCATION (City, town, or county) <u>Whaleynelle, Md.</u>
DATE REC'D BY LOCAL REGIST. <u>7-21-50</u>	REGISTRAR'S SIGNATURE <u>Marydell Hollenay</u>	24. FUNERAL DIRECTOR <u>Peter Whaley</u>	ADDRESS <u>Salisbury, Md.</u>

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUL 25 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07214

7205

CERTIFICATE OF DEATH

Reg. Dist. No. 382

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>				TOWN <u>SALISBURY</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>82 Peninsula General Hospital</u>				<u>415 Bramby Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Twin #1 PARSONS</u>				<u>July 19 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>		<u>July 19 - 1955</u>	<u>Yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Richard Shelton PARSONS</u>				<u>HELEN MARIE GRAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mrs. Helen Gray, Salisbury, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>776X</u> IMMEDIATE CAUSE (A)				<u>Prematurity - Twin</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>6 1/2 months gestation</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/19/55</u> 19 <u>55</u> , to <u>7/19/55</u> 19 <u>55</u> , that I last saw the deceased alive on <u>7/19/55</u> 19 <u>55</u> and that death occurred at <u>5:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>			
DATE <u>7-20-55</u>				DATE SIGNED <u>7/19/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>CREMATION</u>		<u>7/20/55</u>		<u>Peninsula General Hospital</u>		<u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Mary W. Holloway</u>		<u>Peninsula General Hospital</u>			

2075172271

JUL 21 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07215

7228

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY OR TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Salisbury</u>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS <u>415 BRAMBY STREET</u>		1	
3. NAME OF DECEASED (Type or Print) <u>Twin #2, PARSONS,</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 19 1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>July 19-1955</u>	
9. AGE last birthday yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>20</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard Shelton PARSONS.</u>				14. MOTHER'S MAIDEN NAME <u>Helen Marie Gray.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Helen Gray, Salisbury, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
776X IMMEDIATE CAUSE (A) <u>Prematurity - twin - 6 months gestation</u>							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u></u>							
(C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/19/55, 1955, to 7/19/55, 1955, that I last saw the deceased alive on 7/19/55, 1955, and that death occurred at 5:00 P.M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>8/19/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>7/20/55</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital</u>		LOCATION (City, town, or county) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>7-20-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS	

CERTIFICATE OF DEATH

Mass. Dept. of Health

1. NAME OF DECEASED (PRINT OR TYPE)

MASSACHUSETTS

COUNTY OF

CITY OF

STATE OF

AGE

SEX

RACE

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Burial Officer

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Interment

Signature of Burial

Signature of Cremation

Signature of Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

Signature of Final Disposition

BUREAU V. 2

JUL 21 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7229

CERTIFICATE OF DEATH

07216

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WICOMICO</u>		STATE <u>MD</u> COUNTY <u>WICOMICO</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>MARDELA</u>		LENGTH OF STAY (in this place) <u>30 yrs</u>		CITY OR TOWN <u>MARDELA</u>		CITY OR TOWN <u>MARDELA</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SCHOOL ST</u>		STREET ADDRESS (If rural give location) <u>SCHOOL ST</u>		STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>AMY ELIZABETH PHILLIPS</u>				<u>JULY 11 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, <u>WIDOWED</u> , DIVORCED, (Specify)	8. DATE OF BIRTH <u>OCT 20, 1865</u>	9. AGE last birthday <u>89</u> yrs.	10. UNDER 1 YEAR (Months) (Days)		11. UNDER 24 HRS. (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM DARBY</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>HOME</u>		17. INFORMANT & ADDRESS <u>MRS ALICE BENNETT</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>31</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Tuberculosis disease</u>						<u>10</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 10, 1955</u> , to <u>July 11, 1955</u> , that I last saw the deceased alive on <u>July 10, 1955</u> , and that death occurred at <u>8:45</u> M. from the causes and on the date stated above.							
SIGNATURE <u>D. S. Kuhlman</u> M.D.				ADDRESS (Street, city, town, state) <u>Shapton MD</u>		DATE SIGNED <u>7/13/55</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>7/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>MARDELA</u>		LOCATION (City, town, or county) <u>MARDELA MD</u>	
24. REC'D BY REGISTRAR <u>July 18, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Paul G. Smith</u>		ADDRESS <u>Shapton MD</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

NEWLAND

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

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DATE OF REEXHUMATION

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DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

BUREAU V. 1

JUL 18 1955

RECEIVED

ENCLOSURE

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE, 18

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

I TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7230

07217

CERTIFICATE OF DEATH

Dr. Lewis

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN Willards				TOWN Willards		in village	
HOSPITAL OR INSTITUTION OR STREET ADDRESS No street Address				STREET ADDRESS (If rural give location) No street Address			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ROSCOE (Middle) JAMES (Last) PHILLIPS				(Month) July (Day) 28th (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	10. IF UNDER 1 YEAR	
Male	White	Married	Sept. 16, 1902		52 yrs.	10 Months 12 Days	19 Hours 55 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) R.D. # Pittsville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James H. Phillips				14. MOTHER'S MAIDEN NAME Cleora Brunbley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) unk (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Alice D. Phillips (Wife) Willards Maryland	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
156.1 IMMEDIATE CAUSE (A) Adenocarcinoma of liver				INTERVAL BETWEEN ONSET AND DEATH 6mo?			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 7-22-55		19b. MAJOR FINDINGS OF OPERATION Liver adenocarcinoma		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street-office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7-22-55 to 7-28-55, that I last saw the deceased alive on 7-28-55, and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
SIGNATURE Frank Lewis				DATE SIGNED July 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF July 31, 1955		NAME OF CEMETERY OR CREMATORY Lewis Cemetery	
24. REC'D BY REGISTRAR Aug. 1, 1955				REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY	
				LOCATION (City, town, or county) Near Willards, Maryland		ADDRESS SALISBURY, MARYLAND	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

File No. 44

Mr. Lewis

Place of Birth: Wisconsin
 Date of Birth: July 18, 1900
 Sex: Male
 Race: White
 Marital Status: Married
 Occupation: Farmer
 Address: R.D. 1, Pittsville, Maryland

Signature: James A. Phillips
 Date: July 18, 1955
 Place: Pittsville, Maryland

Signature: Mrs. Alice G. Phillips (Wife) Phillips
 Date: July 18, 1955
 Place: Pittsville, Maryland

Signature: [Illegible]
 Date: July 18, 1955
 Place: Pittsville, Maryland

Signature: [Illegible]
 Date: July 18, 1955
 Place: Pittsville, Maryland

Signature: [Illegible]
 Date: July 18, 1955
 Place: Pittsville, Maryland

Signature: [Illegible]
 Date: July 18, 1955
 Place: Pittsville, Maryland

Signature: [Illegible]
 Date: July 18, 1955
 Place: Pittsville, Maryland

Signature: [Illegible]
 Date: July 18, 1955
 Place: Pittsville, Maryland

Signature: [Illegible]
 Date: July 18, 1955
 Place: Pittsville, Maryland

Signature: [Illegible]
 Date: July 18, 1955
 Place: Pittsville, Maryland

RECEIVED

BUREAU V. 8

AUG 1 1955

RECEIVED

WOLFGANG & COMPANY, BALTIMORE, MARYLAND

1 hours after death.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7207

07218

CERTIFICATE OF DEATH

Dr. Gramse

Reg. Dist. No. 332

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Wicomico	MARYLAND	STATE Maryland	COUNTY Wicomico
CITY (If outside corporate limits, write RURAL or and give nearest town) Salisbury	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Hill Private Sanitarium		STREET ADDRESS 206 East Isabella St	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) ALLIE ELIZABETH RUSSELL		4. DATE OF DEATH (Month) (Day) (Year) July 15 th 19 55	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Nov. 9, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE last birthday 83 yrs. IF UNDER 1 YEAR (Months) 8 (Days) 6 IF UNDER 24 HRS. (Hours) Min.
11. BIRTHPLACE (State or foreign country) Queenx Ann County Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. Shuster		14. MOTHER'S MAIDEN NAME Tabitha Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Mrs. Helen T. Chandler-(Daughter) 411 Poplar Hill Ave. Salisbury, Maryland			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
331X IMMEDIATE CAUSE (A) Cerebro-Vascular Accident			sudden
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1946 to 7/15, 1955, that I last saw the deceased alive on 7/15, 1955, and that death occurred at 6:20P.M. from the causes and on the date stated above.			
SIGNATURE Frederic R. Gramse		DATE SIGNED July 16 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		NAME OF CEMETERY OR CREMATORY Chester Cemetery	
DATE THEREOF July 18, 1955		LOCATION (City, town, or county) (State) Chestertown, Maryland	
24. REC'D BY REGISTRAR July 18, 1955		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Dr. George

Alconio

Salisbury

Spring Hill Private Sanatorium

Albia

Missouri

Missouri

July

Nov. 9, 1955

Female

White

House Work

None

Doctor and Family Physician

Taxidermist

John L. Gentry

John L. Gentry, Taxidermist, 1111
Spring Hill Ave., Salisbury, Maryland

BUREAU V. 2

JUL 18 1955

RECEIVED

South Division of Baltimore, Md.

6:30P.

July 18, 1955

Male

Greater Cemetery

INDIRECT & COCAINE LABORATORY BALTIMORE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07219

7208

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		27 days		OR TOWN <u>Hurlock</u>		09X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Sylvia</u> <u>Smith</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July</u> <u>22</u> <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1/22/1922</u>	9. AGE last birthday <u>33</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James C. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Beatrice Dyce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						?	
171X IMMEDIATE CAUSE (A) <u>Generalized carcinomatosis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Squamous cell Ca. of cervix uteri</u>						1 year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Secondary anemia</u>						?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 27</u> , 19 <u>55</u> , to <u>July 22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 22</u> , 19 <u>55</u> , and that death occurred at <u>9:25 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L.V. Maldve</u>		L.V. Maldve, M.D. ADDRESS (Street, city, town, state) <u>Deer's Head State Hospital Salisbury, Maryland</u>		DATE SIGNED <u>7/23/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Friendship Memorial Cemetery</u>		LOCATION (City, town, or county) <u>Washington, D.C.</u>	
24. REC'D BY REGISTRAR <u>Mary H. Hollingsworth</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Crouch</u>		ADDRESS <u>51 K St. NW Washington D.C.</u>	
DATE <u>7/27/55</u>							

CERTIFICATE OF DEATH

Reg. Dist. No.

Local Health Officer's Signature

Physician's Signature

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF EXAMINATION

PLACE OF EXAMINATION

SIGNATURE OF PHYSICIAN

SIGNATURE OF LOCAL HEALTH OFFICER

DATE OF SIGNATURE

PLACE OF SIGNATURE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF EXAMINATION

PLACE OF EXAMINATION

SIGNATURE OF PHYSICIAN

SIGNATURE OF LOCAL HEALTH OFFICER

DATE OF SIGNATURE

PLACE OF SIGNATURE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF EXAMINATION

PLACE OF EXAMINATION

SIGNATURE OF PHYSICIAN

SIGNATURE OF LOCAL HEALTH OFFICER

BUREAU V. S.

JUL 28 1955

RECEIVED

7231

07220

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <input checked="" type="checkbox"/> TOWN Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 4				STREET ADDRESS (If rural, give location) R.D. # 4			
3. NAME OF DECEASED: (First) LINDA (Middle) MAE (Last) STEVENS		4. DATE OF DEATH JULY 18 th 19 55		5. SEX: Female		6. COLOR OR RACE: White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Baby		8. DATE OF BIRTH: May 28, 1955		9. AGE last birthday: 0 yrs. 1 months 20 days		10. IF UNDER 1 YEAR: 1 months 20 days	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None		10b. KIND OF BUSINESS OR INDUSTRY: None		11. BIRTHPLACE (State or foreign country): Pen. Gen. Hosp. Salisbury Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Herman Stevens				14. MOTHER'S MAIDEN NAME: Thelma Pennell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: Mrs. Thelma Stevens (Mother) R.D. # 4 Salisbury Maryland			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 48 hours			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) Broncho pneumonia							
Antecedent cause(s) (b) Infected & bitten							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE Paul Rye CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 7-19-55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF July 20, 1955		NAME OF CEMETERY OR CREMATORY Friendship Cemetery		LOCATION (City, town, or county) (State) Near Pittsville, Maryland	
DATE REC'D BY LOCAL REG. 7-20-55		REGISTRAR'S SIGNATURE Mary W. Holloway		24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

2055323395

Washington

Washington

Washington

Washington

Washington

JUL 14 1951

WASHINGTON

WASHINGTON

WASHINGTON

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JUL 28, 1951

1951

1951

1951

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

Mr. J. Edgar Hoover

Washington, D.C.

Washington, D.C.

Enclosed for the Bureau are two copies of a letterhead memorandum dated July 14, 1951, from the Department of Justice, Washington, D.C., to the Federal Bureau of Investigation, Washington, D.C., regarding the activities of the American Friends Service Committee (AFSC) in connection with the Korean War.

cc

BUREAU V. 3

JUL 28 1951

RECEIVED

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

7229

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
12 TOWN <u>Salisbury</u>		2 Days		<u>Girdletree</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>Peninsula General Hospital</u>				<u>23X-2</u>		✓	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Maggie M Stuegis</u>				<u>July 30 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		8. DATE OF BIRTH: <u>June, 19, 1885</u>		9. AGE last birthday: <u>70</u> yrs.	
		SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Housewife</u>				10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Churn Home</u>		11. BIRTHPLACE (State or foreign country): <u>Girdletree, Md</u>	
13. FATHER'S NAME: <u>William Merritt</u>				12. CITIZEN OF WHAT COUNTRY: <u>U.S.A</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service): <u>no</u>				16. SOCIAL SECURITY NO.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Mr. Joseph Andrews Girdletree</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
451X IMMEDIATE CAUSE (A) <u>Diseasing Aneurysm</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>7/28</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/28</u> , 19 <u>55</u> , to <u>7/30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/29</u> , 19 <u>55</u> , and that death occurred at <u>1:30</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>William W. Gray</u>				ADDRESS <u>Salisbury Md</u>		DATE SIGNED <u>8/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-1-53</u>		<u>Baptist Cemetery</u>		<u>Girdletree Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>7-2-53</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollonay</u>		24. FUNERAL DIRECTOR <u>Clay E. Dennis</u>		ADDRESS <u>Snor Hill, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 4 1955

BUREAU V.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07222

7210

CERTIFICATE OF DEATH

Item 5, FilmG185 8-15-55 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Peninsula General Hospital</u>				<u>ATLANTIC Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>George</u> (Middle) <u>Edward</u> (Last) <u>TATUM</u>				(Month) (Day) (Year)			
<u>George Edward TATUM</u>				<u>July 30 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>Now Been</u>	<u>July 28, 1955</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>				<u>P.G. Hospt. Salisbury, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George H. Tatum</u>				<u>Norma Blech</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Mr. George H. Tatum (Father)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
760.5 IMMEDIATE CAUSE (A) <u>Cerebral Edema and multiple</u>				16. MEDICAL CERTIFICATION <u>Atlantic Ave, Salisbury, Md.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>pericardial hemorrhages</u>				16. MEDICAL CERTIFICATION <u>Atlantic Ave, Salisbury, Md.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Prematurity</u>				16. MEDICAL CERTIFICATION <u>Atlantic Ave, Salisbury, Md.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				16. MEDICAL CERTIFICATION <u>Atlantic Ave, Salisbury, Md.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-30-1955</u> to <u>7-30-1955</u> , that I last saw the deceased alive on <u>7-30-1955</u> , and that death occurred at <u>8:07</u> M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Robert H. Saunders Jr.</u> M.D. <u>9264 Driveway St Salisbury</u>				<u>Salisbury, Md.</u>		<u>8/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>Aug. 3, 55</u>		<u>Wicomico Mem. Park</u>		<u>Salisbury, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Aug 3, 1955</u>		<u>Mary H. Holloway</u>		<u>Holloway & Co. Salisbury, Md.</u>			

20705342393

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

7211

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (In this place) 4 wks.		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital				STREET ADDRESS (If rural give location) 215 E. Isabella St.			
3. NAME OF DECEASED (First) (Middle) (Last) ELLA DUKES THORNTON				4. DATE OF DEATH (Month) (Day) (Year) 7 17 1955			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH Mar. 22, 1883	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		9. AGE last birthday 72 yrs.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph G. Davis		14. MOTHER'S MAIDEN NAME Gertrude Elizabeth Davis		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT & ADDRESS William T. Thornton, Sr. — same		18. MEDICAL CERTIFICATION		19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.		170X IMMEDIATE CAUSE (A) Abdominal Carcinomatosis		170X IMMEDIATE CAUSE (A) Abdominal Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma of breast, left.		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		6 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/1 1955 , to 7/17 1955 , that I last saw the deceased alive on 7/17 1955 , and that death occurred at 4:55 P.M. from the causes and on the date stated above.							
SIGNATURE William H. Fisher, Jr. M.D.				ADDRESS (Street, city, town, state) Salisbury Md 21851			
23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		DATE THEREOF 7/19/1955		NAME OF CEMETERY OR CREMATORY Grace Cemetery		LOCATION (City, town, or county) (State) Pittsville, Maryland	
24. REC'D BY REGISTRAR July 21, 1955		REGISTRAR'S SIGNATURE Mary W. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE The Hill & Johnson Co.		ADDRESS Salisbury, Md	

CERTIFICATE OF DEATH

Name of Deceased William T. Thompson, Sr.		Sex Male		Date of Birth Mar. 28, 1882		Place of Birth Germany	
Residence 111 E. Lombard St.		Cause of Death Heart Disease		Date of Death Mar. 28, 1955		Place of Death Home	
Signature of Physician George C. Davis		Signature of Coroner William T. Thompson, Sr.		Signature of Registrar John A. Davis		Signature of Burial Officer John A. Davis	

William T. Thompson, Sr.
Coroner

BUREAU V. 1

MAR 21 1955

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this time, the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

07224

CERTIFICATE OF DEATH

Dr. W. B. Smith

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS Belmont Ave.			
3. NAME OF DECEASED (Type or Print) ETTIE VAUGHN TINGLE				4. DATE OF DEATH July 23 rd 19 55			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH Aug. 11, 1893	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY at Home		9. AGE last birthday 61 yrs.		11. BIRTHPLACE (State or foreign country) Parsonsburg, Maryland	
13. FATHER'S NAME Elijah Driscoll				14. MOTHER'S MAIDEN NAME Ada Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				17. INFORMANT & ADDRESS Mr. Garland D. Tingle (Husband) Belmont Ave. Salisbury, Maryland			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE (A) Circulatory Collapse							
ANTECEDENT CAUSE(S) DUE TO (B) Propagating Thrombus (artery)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Atherosclerosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 1, 1955 , to July 23, 1955 , that I last saw the deceased alive on 7-23 , 19 55 , and that death occurred at 12 M, from the causes and on the date stated above.							
SIGNATURE W. B. Smith				ADDRESS (Street, city, town, state) N. Division St. Salisbury, Md.			
DATE SIGNED July 26 1955				DATE SIGNED July 26 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 26, 1955		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR July 28, 1955		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY			
				ADDRESS SALISBURY MARYLAND			

CERTIFICATE OF DEATH

Dr. J. M. Smith

12-12-1955

Address

Belmont Ave.

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Belmont Ave.

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BUREAU V. 2

JUL 28 1955

RECEIVED

July 28, 1955

July 28, 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07225

7213

CERTIFICATE OF DEATH

Reg. Dist. No. 332 77

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		3 years		OR TOWN <u>Catonsville</u>		03-52-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
91 <u>Deer's Head State Hospital</u>				315 Ingleside Avenue			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>LAWRENCE ALLEN TRIPLETT</u>				<u>July 16 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Divorced</u>	<u>2/19/1909</u>	<u>46</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Paymer</u>		<u>AGRICULTURE</u>		<u>Soldiers Delight</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Horace E. Triplett</u>				<u>B. Nettie Dell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<u>Unk NO</u>			<u>NO</u>		<u>Hospital records</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
462.1 IMMEDIATE CAUSE (A) <u>Gastro-intestinal hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						<u>2 hrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>Esophageal varicosities</u>							
STATING UNDERLYING CAUSE LAST. (C) <u>Post encephalitic Parkinson's disease</u>						<u>?</u>	
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<u>-</u>				<u>-</u>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>-</u>		<u>-</u>		<u>-</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>-</u>		<u>M.</u>		<u>-</u>			
22. I hereby certify that I attended the deceased from <u>July 29, 1952</u>, to <u>July 16, 1955</u>, that I last saw the deceased alive on <u>July 16, 1955</u>, and that death occurred at <u>9:55AM</u>, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>R. J. Gore</u>				<u>R. J. Gore, M.D.; Deer's Head State Hospital</u>		<u>7/16/55</u>	
<u>M. D.</u>				<u>Salisbury, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-18-55</u>		<u>Ward's Chapel</u>		<u>Baltimore Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>7-17-55</u>		<u>E. Harry [Signature]</u>		<u>[Signature]</u>		<u>[Address]</u>	

CERTIFICATE OF DEATH

Reg. File No.

1. LOCAL RESIDENCE, HOME OF DECEASED

2. NAME OF DECEASED
3. SEX
4. AGE
5. DATE OF BIRTH

6. OCCUPATION
7. MARITAL STATUS

8. PLACE OF BIRTH
9. DATE OF DEATH

10. CAUSE OF DEATH
11. MANNER OF DEATH

12. PLACE OF DEATH

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF CLERK

17. SIGNATURE OF DECEASED

18. SIGNATURE OF NEXT OF KIN

19. SIGNATURE OF BURIAL SOCIETY

20. SIGNATURE OF CHURCH

21. SIGNATURE OF FUNERAL HOME

22. SIGNATURE OF CEMETERY

23. SIGNATURE OF STATE DEPARTMENT OF HEALTH

24. SIGNATURE OF COUNTY DEPARTMENT OF HEALTH

25. SIGNATURE OF CITY DEPARTMENT OF HEALTH

26. SIGNATURE OF TOWNSHIP DEPARTMENT OF HEALTH

27. SIGNATURE OF DISTRICT DEPARTMENT OF HEALTH

28. SIGNATURE OF COUNTY DEPARTMENT OF HEALTH

29. SIGNATURE OF CITY DEPARTMENT OF HEALTH

30. SIGNATURE OF TOWNSHIP DEPARTMENT OF HEALTH

31. SIGNATURE OF DISTRICT DEPARTMENT OF HEALTH

32. SIGNATURE OF COUNTY DEPARTMENT OF HEALTH

33. SIGNATURE OF CITY DEPARTMENT OF HEALTH

34. SIGNATURE OF TOWNSHIP DEPARTMENT OF HEALTH

35. SIGNATURE OF DISTRICT DEPARTMENT OF HEALTH

36. SIGNATURE OF COUNTY DEPARTMENT OF HEALTH

37. SIGNATURE OF CITY DEPARTMENT OF HEALTH

38. SIGNATURE OF TOWNSHIP DEPARTMENT OF HEALTH

39. SIGNATURE OF DISTRICT DEPARTMENT OF HEALTH

40. SIGNATURE OF COUNTY DEPARTMENT OF HEALTH

41. SIGNATURE OF CITY DEPARTMENT OF HEALTH

42. SIGNATURE OF TOWNSHIP DEPARTMENT OF HEALTH

43. SIGNATURE OF DISTRICT DEPARTMENT OF HEALTH

44. SIGNATURE OF COUNTY DEPARTMENT OF HEALTH

45. SIGNATURE OF CITY DEPARTMENT OF HEALTH

46. SIGNATURE OF TOWNSHIP DEPARTMENT OF HEALTH

47. SIGNATURE OF DISTRICT DEPARTMENT OF HEALTH

48. SIGNATURE OF COUNTY DEPARTMENT OF HEALTH

49. SIGNATURE OF CITY DEPARTMENT OF HEALTH

50. SIGNATURE OF TOWNSHIP DEPARTMENT OF HEALTH

51. SIGNATURE OF DISTRICT DEPARTMENT OF HEALTH

52. SIGNATURE OF COUNTY DEPARTMENT OF HEALTH

53. SIGNATURE OF CITY DEPARTMENT OF HEALTH

54. SIGNATURE OF TOWNSHIP DEPARTMENT OF HEALTH

55. SIGNATURE OF DISTRICT DEPARTMENT OF HEALTH

BUREAU V. 3

JUL 19 1955

RECEIVED

1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07226

7232

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Delmar		10 yrs		TOWN Delmar			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
RFD # 3				RFD # 3			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Anna		(Middle) Elizabeth		(Last) Truitt		(Month) July (Day) 29 (Year) 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Widowed	Aug. 2, 1870	84	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
At Home			At Home		Wicomic County, Md.		USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Jehu White				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		William Truitt, Delmar, Del.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
571.1 IMMEDIATE CAUSE (A) Gastro enteritis, acute						INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis generalized atherosclerosis heart disease fractured pelvis						10 yrs 4 weeks	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 28, 1955, to July 29, 1955, that I last saw the deceased alive on July 28, 1955, and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
SIGNATURE W.S. Marvel				ADDRESS (Street, city, town, state) 303 East Street, Delmar, Md.		DATE SIGNED 7-30-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		7-31-55		Hebron Cemetery,		Hebron, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Aug 1, 1955		Mary H. Hallaway		W.S. Marvel Co - Delmar, Del.			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Aug 1, 1935</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>At home</i>	
7. CAUSE OF DEATH <i>Heart failure</i>		8. DISEASE OR INJURY <i>Myocardial infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. B. Brown</i>		11. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		12. SIGNATURE OF WITNESSES <i>John A. Smith, John B. Brown</i>	

RECEIVED
 AUG 1 1935
 BUREAU V. B.
John A. Smith
John B. Brown

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07227

7214

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		# Yrs <u>8</u>		TOWN <u>Pittsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Ocean City Bk</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MARY FLORENCE TRUITT</u>				<u>7 1 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Dec. 14, 1871</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Wife</u>		<u>Own Home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Mathai Tingle</u>				<u>Mary</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>				<u>None</u>		<u>Mrs. J. Morris Jones, Same</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>443X</u> IMMEDIATE CAUSE (A) <u>Chronic myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>				<u>2 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>				<u>5 yrs</u>			
				<u>5 yrs.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1950</u> , 19 <u>55</u> , to <u>7-1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7-1</u> , 19 <u>55</u> , and that death occurred at <u>11-30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Frank R. Lewis</u>				ADDRESS (Street, city, town, state) <u>Wicomico Md.</u>		DATE SIGNED <u>7-2-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7/3/55</u>		<u>Line Church Cemetery</u>		<u>Wicomico Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>JUL 5 1955</u>		<u>Mary W. Hollaway</u>		<u>Norman T. Baker</u>		<u>The Hill & Johnson Co. Salisbury, Md.</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED MILTON A. BROWN		AGE 45	SEX Male	RACE White
DATE OF DEATH July 5, 1955		PLACE OF DEATH New York City, N.Y.	CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		
SIGNATURE OF REGISTRAR J. H. Smith		SIGNATURE OF WITNESSES J. H. Smith, M.D. J. H. Smith		

BUREAU V. 1

JUL 5 1955

RECEIVED

The Church Cemetery

1955

1955

7215

07228

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 332

1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury LENGTH OF STAY (in this place)
 TOWN Salisbury
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY WORCESTER
 CITY (If outside corporate limits write RURAL and give nearest town) Ocean City
 TOWN Ocean City 23 X - 2
 STREET ADDRESS (If rural, give location) North 14th St.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

WenTsang

4. DATE OF DEATH

(Month)

(Day)

(Year)

7101955

5. SEX:

M

6. COLOR OR RACE:

Chinese

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

M

8. DATE OF BIRTH:

1917

9. AGE last birthday:

38

yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

Waiter

10b. KIND OF BUSINESS OR INDUSTRY:

Restaurant

11. BIRTHPLACE (State or foreign country):

China

12. CITIZEN OF WHAT COUNTRY:

USA

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Bob Ching, Ocean City, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

954X
Immediate cause

DUE TO

Coronary Artery - Cardiac tamponade

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

Cocaine Anesthesia locally

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 hours

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Fracture of Wore - Ribs of Ribs

19a. DATE OF OPERATION:

7-9-55 (9PM)

19b. MAJOR FINDING OF OPERATION:

Fracture of Wore

20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☒

21b. PLACE (Home, farm, factory, street, office, bldg, etc., INJURY)

Street

21c. (City or town)

(County)

Ocean City Worcester Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

79553P M.21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

Automobile collision while passenger.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Earl L. Rye

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

M. D.

ASSISTANT MEDICAL EXAM.

7-11-55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

7-13-55Evergreen CemeteryBerlin, Md

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

7-14-55Mary W. HollowayAnna C. Burbage, Berlin, Md

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUL 18 1955

RECEIVED

7216

07229

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 332

1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) LENGTH OF STAY (in this place)
 TOWN Salisbury Life
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Wicomico
 CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Salisbury X
 STREET ADDRESS (If rural, give location) RFD #1

3. NAME OF DECEASED:

(First) (Middle) (Last)
Jackie Lou Wallace

4. DATE OF DEATH

(Month) (Day) (Year)
7 15 55

5. SEX:

6. COLOR OR RACE:
F C

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S

8. DATE OF BIRTH:

4-8-54

9. AGE last birthday:

15 Months yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:
None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME:

James Wallace

14. MOTHER'S MAIDEN NAME:

Lizzie Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or date of service)
No

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

Lizzie Wallace-mother.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

491X
 Immediate cause (a) BRONCHO-PNEUMONIA
 DUE TO

Antecedent cause(s) (b) _____
 Diseases or conditions, if any, giving rise to the above cause DUE TO
 stating underlying cause last (c) _____

INTERVAL BETWEEN ONSET AND DEATH
18 hrs.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [Signature]

CHIEF MEDICAL EXAMINER ☒

DATE SIGNED

M. D. DEPUTY MEDICAL EXAMINER ☒

7-17-55

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF

7-17-55

NAME OF CEMETERY OR CREMATORY

Mt. Calvary

LOCATION (City, town, or county)

Fruitland

(State)

Md.

DATE REC'D BY LOCAL REG

7-18-55

REGISTRAR'S SIGNATURE

Mary W. Holloway

24. FUNERAL DIRECTOR

Stewart Funeral Home

ADDRESS

324 E. Church St.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU Y. S.

JUL 20 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07232

7219

CERTIFICATE OF DEATH

Reg. Dist. No. 832

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>5 wks</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>513 Race Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Maggie</u> <u>Washburn</u>				<u>July</u> <u>3</u> <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>June 5, 1903</u>	<u>52</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>at home</u>		<u>Delaware</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Parsons</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>513 Race Street</u> <u>Mrs. Mary A. Myers Salisbury, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
581.0 IMMEDIATE CAUSE (A) <u>Cardiac Insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiac Failure</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Liver</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 27, 1955</u> , to <u>July 3, 1955</u> , that I last saw the deceased alive on <u>July 3, 1955</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. B. Smith</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Md.</u>		DATE SIGNED <u>7/5/55</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6 July 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>July 7, 1955</u>		REGISTRAR'S SIGNATURE <u>Mary Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas H. Wallace</u>		ADDRESS <u>Salisbury, Md.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF BURIAL PLACE	

Robert H. [illegible]
Robert H. [illegible]
Robert H. [illegible]

BUREAU V. 8

JUL 7 1955

RECEIVED

INSTRUCTIONS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07233

7220

CERTIFICATE OF DEATH

Dr. Mitchell

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
12 TOWN Salisbury				TOWN Salisbury		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 Pen. Gen. Hospital				R.D. # 2 Pacific Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. AGE last birthday	
(First) VELMA (Middle) MAE (Last) WHITE				(Month) JULY (Day) 24 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	Nov. 17, 1902	52 yrs.	Months 7	Days 7	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House Work		at Home		Salisbury, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Milbourne Smith				Emma Jane Foskey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No							
17. INFORMANT & ADDRESS							
Mr. George F. White (Husband) 409 Elizabeth St. Salisbury, Maryland							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
191X IMMEDIATE CAUSE (A) Metastatic carcinoma						about 10/54	
ANTECEDENT CAUSE(S) DUE TO (B) Epithelioma of vulva with metastasis						to 7/24/55	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10/21/54; 11/1/54				Epidermoid carcinoma with metastases			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/19/54 19 54 , to 7/24/55 19 55 , that I last saw the deceased alive on 7/24/55 19 55 , and that death occurred at 4:55P. M, from the causes and on the date stated above.							
SIGNATURE W. A. Brule				DATE SIGNED July 27 1955			
ADDRESS (Street, city, town, state)				ADDRESS Maryland Ave. Salisbury, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		July 28, 1955		Parsons Cemetery		Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE July 29, 1955		Mary H. Holloway		HOLLOWAY & COMPANY		SALISBURY MARYLAND	

CERTIFICATE OF DEATH

Dr. Mitchell

DATE OF DEATH

LOCATION

RESIDENCE

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

NAME OF HOSPITAL

NAME OF PHYSICIAN

SEX

AGE

DATE

TIME

CAUSE

WHITE

MALE

AT HOME

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BUREAU V. M.

JUL 29 1955

RECEIVED

DATE

TIME

DATE

TIME

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07234

7233

CERTIFICATE OF DEATH

Reg. Dist. No. 336

1. PLACE OF DEATH COUNTY Wicomico CITY OR TOWN Delmar HOSPITAL OR INSTITUTION OR STREET ADDRESS RFD # 1		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wicomico CITY OR TOWN Delmar STREET ADDRESS RFD # 1	
3. NAME OF DECEASED (Type or Print) Artimisha S. Williams		4. DATE OF DEATH July 3 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE MARRIED WIDOWED DIVORCED Widowed	8. DATE OF BIRTH Sept. 5, 1871
9. AGE last birthday 83 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Wicomico County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin S. Figgs		14. MOTHER'S MAIDEN NAME Mary Jane Maddox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Blanch Cordrey, Delmar, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 592X IMMEDIATE CAUSE (A) Myocardial Cornea ANTECEDENT CAUSE(S) DUE TO (B) Chronic Refractive Psychosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 days 4 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 15, 1954 , to July 3, 1955 , that I last saw the deceased alive on July 3, 1955 , and that death occurred at 7:15 P.M. from the causes and on the date stated above. SIGNATURE L. H. Fyfe ADDRESS Delmar, Del. DATE SIGNED July 6/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE Melsons LOCATION (City, town, or county) Delmar, Maryland (State)	
25. FUNERAL DIRECTOR'S SIGNATURE W. S. Marvel Co - Delmar, Del. ADDRESS			
DATE July 5, 1955			

7221

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
12 TOWN <u>Salisbury</u>				TOWN <u>Pocomoke</u>		23X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
82 <u>Peninsula General Hospital</u>				<u>RR #2, Box 305</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>ISAAC</u> <u>Williams</u>				DATE OF DEATH: <u>July 1</u> 19 <u>55</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>col.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <u>Jan 16, 1898</u>	
						9. AGE last birthday <u>57</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>creator</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Painting</u>			
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY: <u>USA</u>			
13. FATHER'S NAME: <u>Emerson Williams</u>				14. MOTHER'S MAIDEN NAME: <u>Ellen Dennis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>World War I</u>				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS: <u>Annie F. Williams</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>		24 hrs.	
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-30, 1953, to 7-1, 1955, that I last saw the deceased alive on 7-1, 1955, and that death occurred at 8:50 P. M, from the causes and on the date stated above.

SIGNATURE <u>William R. - Ellis J.</u>		ADDRESS <u>Salisbury, Md.</u>		DATE SIGNED <u>7-2-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)	
	<u>7-10-55</u>	<u>Unville Cemetery</u>	<u>Pocomoke, Md.</u>		
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS		
<u>7-2-55</u>	<u>Mary W. Holloway</u>	<u>Wharton & Savage</u>	<u>New Church, Va</u>		

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JUL 6 1955

BUREAU V. 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7234

07236

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Mardela</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Mardela</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R F D 1</u>				STREET ADDRESS (If rural, give location) <u>R F D # 1</u>			
3. NAME OF DECEASED: (First) <u>Julia</u>		(Middle) <u>Alenia</u>		(Last) <u>Wilson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7-19-55</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>	8. DATE OF BIRTH: <u>6-9-1917</u>	9. AGE last birthday: <u>38</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>School</u>		11. BIRTHPLACE (State or foreign country): <u>Mardela Springs</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Robert Horsey</u>				14. MOTHER'S MAIDEN NAME: <u>Addie Jefferson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Unk</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>213-22-6311</u>		17. INFORMANT & ADDRESS: <u>Mrs. Annie M. Waller, Mardela, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>150X</u> Immediate cause (a) <u>Metastatic carcinoma of lungs</u> DUE TO Antecedent cause(s) (b) <u>Carcinoma of breasts-bilateral.</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>3 months</u> <u>2 years.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>E. L. Taylor</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>7-21-55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>7-24-55</u>		NAME OF CEMETERY OR CREMATORY <u>John Wesley Cemetery</u>		LOCATION (City, town, or county) (State) <u>Md.</u>	
DATE RECD BY LOCAL REG. <u>7-21-55</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR <u>Mary A. Stewart</u>		ADDRESS <u>324 E. Church St. Salisbury, Maryland</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7217

CERTIFICATE OF DEATH

07230

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
12 TOWN <u>Salisbury</u>		38 Yrs.		Salisbury		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		1	
00 <u>Spring Hill Rd., Rt. 2</u>				<u>Spring Hill Rd. Rt. 2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ALFRED</u> (Middle) <u>ST. GEORGE</u> (Last) <u>WINFREE</u>				7 14 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	Dec. 27, 1887	67 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer		Own Farm		Virginia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Irving S. Winfree				Roberta Sublett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Mrs. Myrtle L. Winfree, Same			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						1 day	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 14th</u> , 19 <u>55</u> , to <u>July 14th</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 14th</u> , 19 <u>55</u> , and that death occurred at <u>9:00 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Abelley Emerson</u>				<u>Helms, Md.</u>		<u>July 15-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		7/17/55		Spring Hill Cemetery		Spring Hill, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
DATE <u>July 18, 1955</u>		<u>May W. Hollaway</u>		<u>The Hill & Johnson Co. Salisbury, Maryland</u>			
				<u>Norman F. Baker</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED: **William H. Hill**
 SEX: **Male** AGE: **74** YEARS
 DATE OF BIRTH: **May 10, 1881**
 PLACE OF BIRTH: **Spring Hill, Md.**

CAUSE OF DEATH: **Stroke**
 PLACE OF DEATH: **Spring Hill, Md.**
 DATE OF DEATH: **July 18, 1955**

SIGNATURE OF PHYSICIAN: **Dr. J. H. Hill**
 SIGNATURE OF FUNERAL HOME: **Spring Hill Cemetery**

BUREAU V. 2

JUL 18 1955

FILED

THE HILL & HONAN CO., BALTIMORE, MARYLAND
 SPRING HILL CEMETERY

7218

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>SOMERSET</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>VENTON</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82</u>		<u>PENINSULA GENERAL Hospital</u>		STREET ADDRESS (If rural give location) <u>P. R. #3, Box 252</u>		✓	
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year)			
<u>EMMA</u>		<u>WOOLFORD</u>		<u>July 26 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>FEMALE</u>	<u>col.</u>		<u>Dec 25, 1901</u>	<u>53</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY:	
<u>Housework</u>		<u>Housewife</u>		<u>Mt Vernon, Ind</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Thomas Winder</u>				<u>Josephine Anderson</u>			
15. WAS DECEASED EVER IN U.S. ARMO FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>9</u>		<u>220-05-1993</u>		<u>John Woolford</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE						<u>16 hrs</u>	
(A) <u>Anabolic Coma</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>Bilateral Pyelonephritis</u>							
(C) <u>Severe Arteriosclerosis P-V Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>21</u>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>7/26</u> , 19 <u>55</u> , to <u>7/27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7/26</u> , 19 <u>55</u> , and that death occurred at <u>1:08 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>William D. Gray</u>		<u>Salisbury Md</u>		<u>7/28/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>7-31-55</u>		<u>Grace Cemetery</u>		<u>Venton, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>7-27-55</u>		<u>Mary W. Holloman</u>		<u>William H. Jones Jr.</u>		<u>Salisbury Md</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. 3

JUL 29 1955

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